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No. 95 110

In The

Supreme Court of the United States

October Term, 1995

RYE PSYCHIATRIC HOSPITAL CENTER, INC.,

Petitioner,

vs.

DONNA E. SHALALA, Secretary, United States Department of Health and Human Services,

Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Does the Social Security Act require that hospitals serving a disproportionate number of low-income patients under TEFRA receive additional payment adjustments to their Medicare allowable costs?

2. Does the adjustment provision statute, 42 U.S.C. § 1395ww(b)(4)(A), which three of four circuit courts of appeals have said applies to TEFRA hospitals after 1983, include the concept of a disproportionate-share adjustment to hospital reimbursement rates for low-income patients based on "case mix"?

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DONNA E. SHALALA, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

Petition For a Writ of Certiorari To The United States Court of Appeals For the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

Rye Psychiatric Hospital Center, Inc.[1] petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit.

1. There are no parent or subsidiary companies of Rye Psychiatric Hospital Center, Inc., to be listed pursuant to Supreme Court Rule 29.1.

OPINIONS BELOW

The opinion of the Court of Appeals (Appendix, *infra*, 3a - 26a) is reported at 52 F.3d 1163 (2d Cir. 1995). The opinion of the District Court (Appendix, *infra*, 27a-41a) is reported at 846 F. Supp. 1170 (S.D.N.Y. 1994).

STATEMENT OF JURISDICTION

The judgment of the Court of Appeals was entered on April 10, 1995. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254 (1).

CONSTITUTIONAL PROVISIONS, STATUTES AND REGULATIONS INVOLVED

The United States Department of Health and Human Services' ("HHS") Medicare regulation challenged in this case, 42 C.F.R. § 412.106(a)(i) and (ii) and the relevant provisions of the federal Medicare Act, 42 U.S.C. §§ 1395ww(a)(1) and (2), (b)(4)(A) and 1395f(b), (2) are reproduced in the Appendix.

STATEMENT OF THE CASE

Petitioner, Rye Psychiatric Hospital, Inc. ("Rye") is one of approximately two thousand hospitals and hospital units in the United States reimbursed for their allowable costs of treating Medicare-eligible patients under the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), which provides a payment adjustment for treating a disproportionate number of low-income persons with special needs ("DSA"). TEFRA contains a reimbursement scheme originally intended by Congress to last no more than three years but which, for these hospitals and units, is now into its second decade, with no reimbursement for DSA.

This case involves the denial of the congressionally mandated disproportionate share payment adjustments to Medicare reimbursement to those otherwise qualifying hospitals still reimbursed under TEFRA. Under regulations promulgated by HHS the only reference to whom DSA is paid is to those areas of hospitals "subject to the Prospective Payment System ("PPS") *and excludes all others.*" 42 C.F.R. § 412.106(a)(ii) (emphasis added).

A. The Pertinent History of TEFRA and the Prospective Payment System

Congress' perception of the need for the Secretary of Health and Human Services to make special payment adjustments for hospitals which served low-income patients in disproportionate numbers was embedded in statute before TEFRA was enacted.[2]

TEFRA originated, in part, from congressional dissatisfaction with the previously modified Medicare retrospective reimbursement system through which hospitals were reimbursed their actual, reasonable costs subject to certain limits (the "223 limits"). Social Security Amendments of 1972, Pub. L. No. 92-603, § 223 (b), 86 Stat. 1329, 1393 (1972).

In 1982, Congress concluded that even the modified, reasonable-cost system provided insufficient incentives for hospitals to restrain costs, and enacted the TEFRA reimbursement system as an interim measure for up to three years, while the Secretary of HHS developed a methodology for prospective reimbursement (42 U.S.C. § 1395ww(a)). This interim measure included special instructions for the Secretary to

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2. Pub. L. 97-35, § 2173(b)(1), (d), as amended by Pub. L. 99-409, § 9433(a), adding subsection (h), and striking out former subsection (h), making the 1986 statute effective 1981. 42 U.S.C.A. § 1396a(h) (1992) at 458.

observe regarding disproportionate-share payments to certain hospital groups (42 U.S.C. § 1395ww(a)(2)(B)). Pub. L. No. 97-248, § 101, 96 Stat. 324, 331 (1982) (codified as amended at 42 U.S.C. § 1395ww (a); H.R. Rep. No. 98-25, 98th Cong., 1st Sess. 132, reprinted in 1983 U.S.C.C.A.N. 143, 219, 351.

In 1983, a transition period to PPS was begun in recognition of the severe financial dislocations that could be caused in such hospitals by a sudden change in reimbursement policy. S. Rep. No. 98-23, 98th Cong. 1st Sess. 53, reprinted in 1983 U.S.C.C.A.N. 143, 193. 42 U.S.C. § 1395ww(d). Certain hospitals were temporarily excluded from the new system as subsection (d) was added. 42 U.S.C. § 1395ww(d)(1)(B). The problem here arises from the fact that, despite congressional intent, these excluded hospitals, including Petitioner, not only remained outside the PPS, but the Secretary has never provided DSAs for those hospitals among them which qualified under the statute, making them subject to the very financial dislocations it was Congress' intention to prevent.

Aside from continuation of the 223 limits on actual, reasonable costs (42 U.S.C. § 1395x(v)(1)(A)), and the TEFRA addition of the "rate-of-increase" ceiling (the "expanded 223 limits" of subparagraph (a)(1)(A) of section 1395ww [sunsetted by subparagraph (D) in 1983], Pub.L. 98-21 § 601(a)(1)), the distinguishing features of the TEFRA reimbursement methodology for the transition period were: (1) the establishment of "target amounts," the first of which is the amount of allowable operating costs for the 12 months preceding the first cost reporting period for which it is in effect ((b)(1), (3)); and (2) an annual inflation factor, the "applicable percentage increase" ("API"), to be retrospectively applied to a PPS hospital's discharges and added to the target amount for each reporting period, 42 U.S.C. § 1395ww(b)(3)(A),(B)(i) and, for non-PPS hospitals and subparagraph (C), (D) and (E) hospitals, the API is

applied prospectively to the target amount. Subsection (b)(3)(B)(i), (ii).[3] If allowable operating costs (as defined in subsection (a)(4) are below the target amount a bonus is paid. If they exceed the target amount there is a penalty. 42 U.S.C. § 1395ww (b)(1).[4] The third distinguishing feature of TEFRA was the mandatory exemption, exception and adjustment provision which superseded all of the foregoing cost limits. 42 U.S.C. § 1395ww(b)(4)(A).

The distinguishing features of TEFRA in 1982 for Petitioner-type hospitals were the contemporaneous insertions in section 1395ww of subparagraph (a)(2)(B), subsection (b)(1), (3), and subsection (b)(4)(A) (which would permit adjustments when events occurred "beyond the hospital's control"), taken together with the amendment in section 1395f(b), making it subject to section 1395ww (which included the superseding mandatory adjustment provision of section 1395ww(b)(4)(A)).

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3. Subparagraph (C) is the "sole community" PPS hospital, (D) is the rural PPS hospital. Subparagraph (E) (cancer and research) hospital is defined as not a "subsection (d)" hospital. 42 U.S.C. 1395ww(d)(1)(B)(v). However, all three groups are to have their API's "compounded." The remaining majority of TEFRA hospitals (subparagraph (A)), according to the statute, are not supposed to have their API's compounded by the Secretary. In 1990, the "sole community" and "rural" hospitals — both long within the PPS — were switched from clause (ii) (TEFRA) to (i)(PPS), leaving only subparagraph (A) and (E) hospitals under TEFRA APIs. While TEFRA subparagraph (E) hospitals expressly have a "base cost reporting period," subparagraph (A) (Petitioner-type) hospitals do not. *Compare* subparagraphs (b)(3)(A), (C), (D) and (E) for "base cost reporting period" and "compounding."

4. Of course, this target bonus or penalty is only in relation to the "target" incentive methodology, which existed contemporaneously with the rate-of-increase limits of subsection (a), it had nothing to do in 1982, with the Secretary's continuing responsibility for payment under the subchapter of the hospital's actual Medicare allowable costs as described in subsection (a)(4) and 42 U.S.C. § 1395x(v)(1)(A) — the original 223 limits — which never sunsetted for TEFRA hospitals. *See infra.*

As interpreted by the Secretary's regulations, however, the target amount plus bonus or penalty is all that may be reimbursed no matter how long the hospitals were to remain in TEFRA and, although distinct from the "rate-of-increase ceiling," the target is a ceiling above which operating costs per discharge will not be reimbursed. 42 C.F.R. § 413.40; 47 Fed. Reg. 43286 (1982). The practical result for hospitals like Petitioner's, according to the Secretary's methodology, is that that ceiling has remained frozen at 1982 levels and increases only by compounding the annual prospective inflation factor, the API, producing a steadily widening gap between actual, Medicare allowable costs and "target"-fixed reimbursement. This is the first question answered by the District Court. It was in Petitioner's favor and no appeal therefrom was taken by the government.

After several years of transition, the new PPS system was formally installed in 1986, and continued to be modified. Under PPS, Medicare reimburses hospitals' inpatient operating costs on the basis of prospectively determined national and regional rates, classifying Medicare patients into approximately 470 "diagnosis related groups" ("DRG's") based on anticipated differences in patients' utilization of hospital resources for identified illnesses. The rate to be paid upon the discharge of a given patient is largely determined by the DRG that describes the patient's primary condition.

Congress was persuaded that there were sufficient concerns about the accuracy and fairness of the new system as applied to psychiatric patients and others temporarily excluded from PPS, (these excluded hospitals are, psychiatric, rehabilitation, children's, long-term, certain cancer treatment and research hospitals and distinct-part units [psychiatric and rehabilitation] in general hospitals) (42 U.S.C. § 1395(d)(1)(B)) and inserted, in 1984, paragraph (2) of section 1395(f)(b). Appendix at 45a. It was anticipated that these hospitals soon would be brought into

PPS and the Secretary was directed to include in the December 1985 annual report to Congress the results of studies on "whether and the method under which hospitals, not paid on amounts determined under [PPS] . . ., can be paid for inpatient hospital services on a prospective basis as under [PPS] . . . .," Pub.L. 98-21, § 603(a), as amended by Pub.L. 98-369, § 2317 (1984). In the meantime, non-PPS hospitals continued to be reimbursed under the TEFRA methodology.

Again in 1989, Congress directed the Secretary to submit a proposal not later than October 1, 1989 to include "[r]ecommendations, where appropriate, for modifying reimbursement for hospitals that are not [included in PPS]. . .," Pub. L. 101-239, § 6003(i) (1989). Still, nothing substantive happened.

In 1990, Congress specified that by April 1, 1992 the Secretary "shall develop a proposal to modify the current system under which hospitals that are not subsection (d) [PPS] hospitals . . . receive payment for the operating and capital-related costs of inpatient hospital services under Part A of the Medicare program . . . or a proposal to replace such system with a system under which such payments would be made on the basis of nationally-determined average standardized amounts." Pub. L. 101-508, § 4005 (b) (1990).

Despite these repeated congressional directives to submit proposals either bringing the excluded hospitals into PPS or modifying the existing system, twelve years after introduction of the "temporary" TEFRA reimbursement methodology these hospitals continue to have their Medicare costs reimbursed under TEFRA and continue to be excluded from DSAs.

The DSA provision, found at 42 U.S.C. § 1395ww (a)(2), states:

> The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account -
>
> * * *
>
> (B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter . . . .

This adjustment reflects congressional awareness in 1982 (and 1983, *see infra*) that certain hospitals which treat significant numbers of low-income or elderly beneficiaries will incur higher costs because such patients' medical conditions require the utilization of more resources than other patients not so financially vulnerable, a situation for which Congress had not provided in 1972 when enacting the original "section 223 limits." 42 U.S.C. § 1395x(v)(1)(A). Because of the upper limits set by TEFRA in subsection (a)(1)(A), it was necessary to furnish an adjustment to the reimbursement rate to ensure that all hospitals received fair compensation for the services provided. So that there should be no ambiguity regarding subparagraph (a)(2) of section 1395ww as a result of the PPS need for subparagraph (D) in 1983, when Congress added a DSA in 1984 to paragraph (2) of 42 U.S.C. § 1395f(b), it tracked the same language as subparagraph (a)(2)(B) of section 1395ww. Pub. L. 98-369, § 2308(b)(2)(A), 42 U.S.C.A. § 1395f(b)(2) (1992). Subsection (d)(5)(C)(i) was enacted for subsection (d) hospitals at the same time as section 1395(f)(b)(2) for TEFRA hospitals, but repealed in 1986 when

the subsection (d)(5)(F) formulae were enacted for the DSA.

As discussed more fully *infra,* the Secretary ignored the DSA requirement in TEFRA, as well as numerous congressional directions to develop a definition of a disproportionate share hospital ("DSH"), and failed to identify even PPS hospitals that met such definition. By 1986, with the Secretary still not having acted, Congress assumed the task itself, and both defined a DSH and created a Medicare adjustment formulae for reimbursement rates for such hospitals. Pub. L. 99-272, § 9105(a), 42 U.S.C.A. § 1395ww(d)(5)(F) (1992).[5] However, as of this date, the Secretary still refuses to pay a DSA to any hospital reimbursed under TEFRA, including Rye, restricting such adjustments to PPS hospitals.

B. Petitioner's Request for Review

Rye requested an expedited review determination pursuant to 42 U.S.C. § 1395oo(f)(1), that the Provider Reimbursement Review Board (the "Board") lacked authority to decide, *inter alia,* whether the Secretary's regulation (42 C.F.R. § 412.106) incorrectly interpret the statute by excluding TEFRA hospitals from receiving the DSA or, alternatively, whether, if correctly interpreted by the Secretary, the statute violated the Hospital's constitutional rights of due process and equal protection of law.

On May 8, 1992 the Board made the requested determination and granted Rye's request for expedited judicial review. The Hospital timely filed its action for declaratory and injunctive

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5. In the same year, it enacted Medicaid subsection (h) of 42 U.S.C. § 1396a, as of *1981,* prohibited the Secretary from "limit[ing] the amount of payment adjustments that may be made under a [state] plan . . . with respect to hospitals that serve a disproportionate number of low-income patients with special needs . . . ." 42 U.S.C.A. § 1396a(h) (1992) at 458.

relief on June 25, 1992 in the United States District Court for the Southern District of New York. Federal jurisdiction was based upon 28 U.S.C. §§ 1331 and 1336 and 42 U.S.C. § 1395oo.

The parties cross-moved for summary judgment. In an opinion and order dated March 22, 1994 the District Court (Brieant, J.) granted Rye's motion to the extent of holding that the DSA is available through the exemption and adjustment provisions of 42 U.S.C. § 1395ww (b)(4)(A), which require the Secretary to modify any unworkable restrictions of her methodology, while finding that the challenged regulation, 42 C.F.R. § 412.106, is not contrary to the statute. Specifically, the Court held: (1) that (b)(4)(A) requires the Secretary to provide for an exemption, exception or adjustment for change of "case mix," which includes the concept of a significantly disproportionate number of low-income patients, and (2) that the Secretary has the duty to uphold the statute "whether or not repeated in the regulations." 846 F. Supp. at 1183. A final declaratory judgment was entered on April 29, 1994.

On appeal and cross-appeal to the Court of Appeals for the Second Circuit, the Court reversed, finding that the DSA is not available to non-PPS hospitals under section 1395ww(b)(4)(A) because such hospitals are already reimbursed for the higher costs of treating sicker patients by the "cost-based" TEFRA system and that the terms of the "adjustment provision" do not include a DSA.

REASONS FOR GRANTING THE PETITION

The Second Circuit's decision is the only decision by an appellate court to consider the availability of the DSA to non-PPS hospitals. It should be reviewed for two reasons: first, because the decision misconstrues important federal statutes in a manner that frustrates clear congressional intent, and violates petitioner's

rights to equal protection and due process of law under the United States Constitution. The decision results in drastic economic consequences to a class of hospitals and the Medicare beneficiaries that the statutes were intended to protect; and second, the decision raises a significant and unresolved issue of statutory and regulatory interpretation involving the interplay between the TEFRA and PPS Medicare reimbursement systems which also have been the subject of conflict among several courts of appeals.

Review of the Court of Appeals' decision will provide this Court with the opportunity to settle the important question of Medicare reimbursement left by the regulatory void and to further refine the principles of statutory construction under *Chevron U.S.A. Inc. v. Natural Resources Defense Council,* 467 U.S. 837 (1984) and *Thomas Jefferson University v. Salala,* 114 S. Ct. 2381 (1994).

The hostility of the agency entrusted with implementation of the DSA to its very concept continues to frustrate the clear will of Congress. In such circumstances, action by this Court is necessary (*cf. Wilkerson v. McCarthy,* 336 U.S. 532, 70-71 (1949) (Douglas, J., concurring)), especially where the importance Congress attached to the DSA is underscored by repeated congressional insistence upon implementation in the face of the Secretary's refusal to act.

At the time DSA was enacted in 1982 in TEFRA it was for Petitioner-type hospitals only (42 U.S.C. § 1395ww (a)(2)(B)). The Secretary based her failure to comply on a lack of data demonstrating that such an adjustment was necessary. 47 Fed.Reg. 43282, 43285 (1982). Congress included a similar directive, once more, in the Social Security Act Amendments of 1983 (Pub. L. 98-21, § 601(e)). Again the Secretary responded that although "explicitly authorized to provide" exemptions,

exceptions, or adjustments considered necessary to take into account the special needs of DSHs, she had been unable to empirically verify the need for a DSA. 48 Fed. Reg. 39412, 39416-17 (1983). Actually the statute is neither declaratory nor discretionary, but mandatory, and says "[t]he Secretary shall provide . . . ."

In January, 1984, the Secretary repeated that she had not made special provisions in the regulations for the special needs of DSH hospitals in PPS (required by then subparagraph 1395ww(d)(5)(c)(i)) "because our current data does not show that an adjustment is warranted." 49 Fed. Reg. 276 (1986).

In *Redbud Hosp. District v. Heckler,* 1984 WL 2857*9 (N.D. Ca. July 30, 1984), the Court had this response:

> The Secretary was not given the discretion to decide whether such hospitals have special needs; she was given discretion only to decide how best to cope with those special needs Congress had already declared to exist. In ignoring this statutory mandate and refusing to recognize and deal with the needs Congress saw, the Secretary has again abuse [sic] her discretion.

Earlier the Secretary had evaded the specific DSA requirement in TEFRA for psychiatric hospitals (42 U.S.C. § 1395ww(a)(2)(B)) in much the same way. In the September 30, 1982 Federal Register the Secretary said:

> We have not now made any special provision for public hospitals or other hospitals that treat a disproportionate number of low income or Medicare patients, because

> we do not now have data that enables us to determine the extent to which special consideration is warranted, or the type of provision that may be appropriate.

47 Fed. Reg. 43285 (1982).

The Secretary, however, while acknowledging the congressional directive for exemptions, exceptions and adjustments required by subparagraph (a)(2), directed the public's attention only to "case mix" as found in subsection (a)(1)(B)(i) for acute short-term hospitals and not to subsection (b)(4)(A), confounding case mix with the need for a DSA for psychiatric hospitals, and called them (irrelevantly) long-term care hospitals" contrary to the formal congressional distinction the next year between the two types. 42 U.S.C. § 1395ww(d)(1)(B).[6] In sum, the phrase "extraordinary circumstances beyond a hospital's control," which never existed in the statute for Petitioner-type hospitals is found today only in the regulations contained in 42 C.F.R. § 413.40(g)(2), (3)(D)(ii),(iii), which the Secretary uses to exclude DSAs from PPS-exempt hospitals.

Again in 1984, Congress ordered the Secretary prior to December 31, 1984, to develop and publish a definition of a DSH and to identify those hospitals meeting such definition. Deficit Reduction Act of 1984 ("DEFRA"), Pub. L. 98-369, § 2315(h), (1984). The Secretary published her final PPS regulations in August, 1984, but did not even mention the DEFRA DSA provisions. 49 Fed. Reg. 34728 (1984).

In July, 1985 the federal district court for the District of

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6. Here lies the distinction between the "case mix" of subsection (a)(1)(B), as ascribed incorrectly by the Secretary and the Court of Appeals to (b)(4)(A), and the term "case mix" as applied correctly by the District Court to DSA required by (b)(4)(A).

Columbia held that under DEFRA the Secretary had a "clear, non-discretionary duty to develop a definition of disproportionate share hospitals and to identify those hospitals to the [Senate Finance and House Ways and Means Committees]." *Samaritan Health Center v. Heckler*, 636 F. Supp. 503, 506 (D.D.C. 1985).

When the Secretary finally promulgated a DSH definition on December 31, 1985, the definition was so limited that of the 5,788 Medicare-certified hospitals only 18 had a chance of qualifying. 50 Fed. Reg. 53398-53400. Yet, the Secretary continued to maintain that "we believe that there is no currently sufficient evidence to demonstrate that an adjustment is warranted." 50 Fed. Reg. at 53399.

It is against this background that Congress in 1985 took the extraordinary step of itself establishing specific DSA formulae and defining a DSH. Comprehensive Omnibus Budget Reconciliation Act of 1985, Pub.L. 99-272, § 9105(a), 42 U.S.C. § 1395ww(d)(5)(F). By 1984, however, Congress already had reaffirmed a DSA for Petitioner-type hospitals. Pub. L. 98-369, § 2308(b)(2)(A), 42 U.S.C.A. § 1395f(b)(2) (1992).

An equal measure of congressional recognition and concern for the burden on hospitals serving large numbers of low-income patients generally is reflected in the Medicare and Medicaid Amendments of 1981 to the Social Security Act, Pub. L. 97-35, § 2173(a)(2)(B),(C), effective Aug. 13, 1981, 98 Stat. 808. These provisions require that in setting rates for reimbursement under Medicaid, state plans "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs" 42 U.S.C. § 1396 a(a)(13)(A), commonly called the "Boren Amendment." The Boren Amendment applies whether states adopt prospective or retrospective reimbursement systems, thus reflecting another congressional decision that no

distinction is to be made in this regard.[7]

A. The Interpretation of the District Court

The decision of the District Court in this action (Brieant, J.) recognized that under the Medicare statute "[h]ospitals providing in-patient services to Medicare eligible patients are entitled to have their reimbursements reviewed to ensure that such payments for necessary services are fair and reasonable." 846 F. Supp. at 1172. This follows the statutory requirement that the amount paid to the provider of services to a significant number of low-income patients be "fair compensation" 42 U.S.C. § 1395f(b)), as well as the directive that the Secretary's regulations determining "reasonable cost" must ensure that the necessary costs of efficiently delivering services to Medicare patients (the original section 223 limits) will not be borne by others. 42 U.S.C. § 1395x(v)(1)(A). Indeed, as the Second Circuit noted in *New York City Health and Hosps. Corp. v. Perales*, 954 F.2d 854, 861 (2d Cir. 1992), *cert. denied*, 113 S. Ct. 461 (1992), "the Senate Report accompanying the Medicare Act [8] evidenced an intent to provide quality medical care for the elderly by compensating providers reasonably for their care. A guarantee of reimbursement, by protecting providers, protects patients."

While the District Court found that the DSA was not

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7. It is, of course, interesting to note that "under a [state] plan" includes the requirements for an approved state plan to agree to "cost-sharing" for Medicare QMBs. 42 U.S.C. § 1396d(p). The foregoing, brings "low-income" persons, as of 1981, into the ambit of all TEFRA and PPS hospitals-to-be and, in 1986 all PPS hospitals, making DSA available to low-income patients in every hospital in the United States certified to treat Medicare or Medicaid patients. *See also*, n.5, *supra*.

8. S. Rep. No. 404, 89th Cong., 1st Sess. 24-27 (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 1965-68.

available to plaintiff under 42 U.S.C. § 1395ww (d)(5)(F), through which the DSA is paid to PPS hospitals, it concluded nonetheless that "hospitals are entitled to have the Secretary modify the restrictive impact of reimbursement criteria based on historical costs *even though adjusted by increments that bear little or no relation to reasonable and necessary actual costs." 846 F. Supp. at 1182 (emphasis added). The Court compared this, to the API-like supports given American companies by the government during this country's efforts in World War II "which lead to shortages where not adjusted to changes in actual—not merely projected—costs." Id.* at 1182 n.37.

Since the DSA is a component of reasonable cost, the District Court found that the component must be recognized under what it called the TEFRA "adjustment provision," 42 U.S.C. § 1395ww(b)(4)(A). 846 F. Supp. at 1182. The statute provides in relevant part:

> The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the Hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured.)[9]

The Secretary's regulations ignore the mandatory "shall provide" for "events beyond the hospital's control" (in the first sentence quoted above) and devise, for adjustments, a

9. The entire subparagraph, including the "discretionary" second sentence of the statute will be found in the Appendix.

discretionary, "extraordinary circumstances beyond the hospital's control," thus restricting "events beyond the hospital's control" to "strikes, fire, earthquake, floods, or similar unusual occurrences with substantial cost effects." 42 C.F.R. § 413.40(g)(2). In place of a statutorily required exemption, exception or adjustment for "events beyond the hospital's control or extraordinary circumstances, including changes in case mix..," the regulation combines the statutory provisions into a concept totally different from that of the statutory command.

Regulation paragraph (g)(3)(ii)(A) through (F) provides that adjustments are to take into account, among other things, "(D) Increases in service intensity or length of stay attributable to changes in the type of patient served." But even here, the Secretary avoids the DSA requirements which she, and the Court below, concede relate to "type of patient served," by selectively excluding subparagraph (D) from consideration for such purposes altogether, since that would obviously lead one to believe DSA was intended. 42 C.F.R. § 413.40(g)(3)(iii).

However, the District Court held that "case mix," mentioned in the first sentence of subparagraph (b)(4)(A) "clearly includes the concept of 'significant [sic] disproportionate number of low income patients,' (d)[5](F) (i)(I),[10] as does the Secretary's inclusion . . . of increases in 'service intensity or length of stay atributable to changes in the type of patient served.' " 846 F. Supp. at 1183.

The Court harmonized the statute and the regulation by noting that all factors in the adjustment provision must be considered whether or not repeated in the regulations. *Id.*

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10. The Court's quotation of subsection (d)(5)(F)(i)(I) is abbreviated. The statute's subclause goes on to refer to the definition of a DSH "(as defined in clause (v))," which refers to the entire subparagraph (F), used also by Medicaid for DSAs. 42 U.S.C. § 1396r-4(c).

B. The Interpretation of the Second Circuit

On the Secretary's appeal, the Second Circuit reversed on several grounds saying first: "a DSA in the context of the TEFRA reimbursement system is unnecessary to take appropriate account of the higher cost of treating low-income patients and, in some circumstances, would lead to overreimbursement" (52 F.3d at 1165), thereby impermissibly substituting its own opinion (and that of the Secretary) of the circumstances in which the DSA is appropriate for that of Congress; second, that subparagraph (2) of 42 U.S.C. § 1395ww(a) does not apply after October 1, 1983 (52 F.3d at 1169), thus impermissibly judicially repealing a portion of that statute; and third, that the "case mix" adjustment provided in subparagraph (b)(4)(A) does not include a DSA (52 F.3d at 1170-72), citing no authority for the latter holding.

The Secretary's use of "case mix," and that of the Court below, has impermissibly removed it from TEFRA and re-engrafted it upon PPS where three Circuit Courts of Appeals have said it does not belong. These three Courts of Appeals now have held that the exemption, exception and adjustment provisions of (b)(4)(A) do not apply to PPS hospitals. *Hillsborough County Hosp. Auth. v. Shalala,* 49 F.3d 1516 (11th Cir. 1995); *Episcopal Hosp. v. Shalala,* 994 F.2d 879, 884 (D.C. Cir. 1993), *cert. denied,* 114 S. Ct. 876 (1994); *Sacred Heart Medical Center v. Sullivan,* 958 F.2d 537, 550 (3d Cir. 1992). The Ninth Circuit has held to the contrary. *Community Hosp. of Chandler v. Sullivan,* 963 F.2d 1206, 1214 n.4 (9th Cir. 1992).

Unquestionably, Congress did provide by amendment in 1983 (Pub. L. § 98-21, § 601 (a)(1)), that "[s]ubparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983." 42 U.S.C. § 1395ww(a)(1)(D). According to the Second Circuit opinion, "[a]s the Section 1395ww (a)(l)(A) cost limits do not apply to periods beginning on or after October

1, 1983, Sections 1395ww(a)(2) and, for that matter, (a)(3) have no bearing with respect to such periods and thus no bearing on Rye's right to reimbursement in any period relevant here. " 52 F.3d at 1170 (footnote omitted).

The Senate Report on TEFRA lists the exemption of psychiatric and other hospitals as among the "more significant features" of the new [PPS] system." "In addition, the Secretary would be *required* to provide exceptions and adjustments for hospitals that serve a disproportionately large number of low-income persons and Medicare beneficiaries. " S. Rep. No. 98-23, at 9, 1983 U.S.C.C.A.N. at 227 (emphasis added).

Having determined that a DSA is necessary for the PPS-exempt hospitals, and providing for it in subparagraph (a)(2) and section 1395f(b)(2), there is no basis to conclude that when Congress meant to eliminate the so-called "expanded section 223 limits" (42 U.S.C. § 1395ww(a)(1)(A)), it also decided that the DSA was no longer necessary, Had it done so, some indication of this conclusion would be found in the legislative history. Instead, Congress carefully timed the phase-out of the expanded 223 limits leaving intact the vital DSA. The Conference Committee Report on TEFRA made it clear that the three year rate-of-increase limits established by section 1395ww(a) would end earlier if PPS was implemented. And that is what happened. H.R. Rep. No. 97-760, 97th Cong. 2d Sess. 421 (1982). The 1983 Amendments reflecting the conferees agreement that the "section 223" limits would no longer apply after October 1, 1983, H.R. Conf. Rep. No. 98-47, 98th Cong., 1st Sess. 193 reprinted in 1983 U.S.C.C.A.N. 143, 483; 42 U.S.C. § 1395ww(a)(1)(D) made no mention of ending the limits set by section 1395x(v)(1)(A).[11]

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11. Clearly, it was the intent to end only the "expanded section 223 limits" established in section 1395ww(a)(1)(A) (H. Rep. No. 98-25 at 151, 1983 U.S.C.C.A.N. at 370), which left the "section 223 limits" of section 1395x(v)(1)(A) undisturbed.

As the same report notes "the Secretary is required to provide *exemptions, exceptions* and *adjustments* to the section 223 limits as he or she deems appropriate to take into account the special needs of psychiatric hospitals" *Id.* (emphasis added), there is certainly no reason to believe that in that report or elsewhere Congress intended to end that requirement. Of course, at that time Congress was not yet fully aware of the Secretary's intention to ignore its admonition.

That Congress did not intend that the DSA provisions of (a)(2)(B) were to sunset on October 1, 1983 along with subparagraph (a)(l)(A) is further demonstrated by its amendment of (a)(2)(B) in 1984. Pub.L. 98-369, § 2354 (b)(42) (1984). Albeit a technical amendment correcting "disportionate" to "disproportionate," there would have been no point to such a belated correction had Congress considered the provision eliminated. As the Second Circuit itself notes, "a statute must be construed to give meaning to each of its parts." 52 F.3d at 1171 (citing *United States v. Nordic Village Inc.*, 503 U.S. 30 (1992); *United States v. Bernier,* 954 F.2d 818, 819 (2d Cir. 1992)).

Also, if Congress had intended subparagraph (a)(2)(B) to sunset it would have specifically so provided by repeal as it did with the repeal of paragragh (b)(2). Judicial policy does not favor repeals of statutes by implication, (*Posadas v. National City Bank,* 296 U.S. 497 (1936); *TVA v. Hill,* 437 U.S. 153, 189 (1978); 1A Sutherland Statutory Construction § 23.10 at p. 54 (5th ed. 1993)), and will not be found unless an intent to repeal is "'clear and manifest'." *United States v. Borden Co.,* 308 U.S. 188,198 (1939) (quoting *Red Rock v. Henry,* 106 U.S. 596 (1883)).

Thus, since the DSA provisions of (a)(2)(B) were neither expressly, implicitly nor judicially repealed, they remain an ignored remnant of the TEFRA system.

If left undisturbed, the decision of the Second Circuit enshrines the proposition that federal courts can repeal portions of statutes they (and, in this case, the Secretary) believe are unnecessary. That notion is repugnant to the constitutional separation of powers since Article III of the Constitution confines the federal courts to adjudicating actual "cases" and "controversies." *See Allen v. Wright,* 468 U.S. 737, 750 (1984). This separation forbids judicial repeal of Acts of Congress. In a practical sense, the Circuit Court decision leaves Petitioner and some two thousand other hospitals and units without the special protection that Congress determined they needed and provided for them.

A further consequence of the abrogation of paragraph (a)(2)(B) is that it is necessary to rely, as the District Court did, on subparagraph (b)(4)(A) to afford the relief intended by Congress. The opinion ofthe Second Circuit rejected this basis as a matter of (1) interpretation of the term "case mix" and (2) deference to the Secretary's construction. 52 F.3d at 1170-72.

Simply put, the Second Circuit agreed with the Secretary that the requirement that she provide an exemption, exception or adjustment for events beyond the hospital's control or extraordinary circumstances, including changes in case mix, does not include the concept of a significantly disproportionate number of low income patients. Such a construction has bizarre and far-reaching results.

First, it ignores the fact that the admission and treatment of Medicare-eligible patients who are also poor is a matter beyond the hospital's control. These are beneficiaries, some of whom are not poor enough to qualify for Medicaid, but who have incomes at or slightly above the poverty line. These patients are known as "qualified Medicare beneficiaries" ("QMBs"), 42 U.S.C. §§ 1396d(p)(1), 1396d(p)(2)(A) and, they, as well as the "dual

eligibles," under the provider contract with Medicare, cannot be turned away. Because the DSA is statutorily mandated for Medicaid (42 U.S.C. §§ 1396a(a)(13)(A), 1396r-4) the portion of charges paid by states under their Medicaid plans for a QMB (deductible and copayment) should also be subject to the DSA. If they are not, the anomalous situation arises where such individuals (conceded by the Court of Appeals to be members of a general mix of non-DRG-identified, low-income patients), will not have their portion of the DSA recognized simply because they are financially *less* vulnerable while having the same *medical* condition.[12] Yet, under the decision below, that part of hospital charges for the same patient reimbursed through Medicare in a TEFRA hospital, or in a PPS-excluded area of a PPS hospital, does not qualify for the adjustment. This results in a forbidden distinction based upon the location of services. *See Connecticut Dep't of Income Maint. v. Heckler,* 471 U. S. 524 (1985).

To make lesser payments to some hospitals for the same or similar services provided to beneficiaries by other hospitals frustrates the specific purpose of developing and providing a coordinated and comprehensive approach to Federal health insurance and medical care for the aged. *See Turecamo v. Comm'r,* 554 F.2d 564 (2d Cir. 1977). Discriminatory control of reimbursement of the costs of hospital care which could lead to reduction of the availability of that care is contrary to the principles upon which health insurance for the aged and disabled Medicare beneficiaries was enacted. *See Hulzman v. Weinberger,* 495 F.2d 1276 (3d Cir. 1974).

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12. Based on a review of State Plans for Medicaid, 35 state plans indicate they provide DSA for Medicaid patients (for QMBs "Medicare cost-sharing" is mandatory for all). CCH ¶¶ 15,501 through 15,660 (1995). It was not through inadvertence either that the DSA subparagraph, 1395ww(d)(5)F)(iv), used for all Medicaid DSHs pursuant to 42 U.S.C. § 1396r-4(c), does not say that its DSAs are not to apply to QMBs in PPS-exempt hospitals.

As the Court said in *New York City Health and Hosps. Corp.*, 954 F.2d at 859, if providers are prevented from collecting their reasonable costs or charges they "will consequently refrain from treating the most vulnerable of the elderly and disabled, those who are also poor . . . . such a result is fundamentally at odds with Congress' vision in enacting the Medicare Act."

While the Second Circuit recognizes the congressional conclusion that low-income patients tend to be in poorer health and therefore cost more to treat, 52 F.3d at 1171-72, it paradoxically takes no account of the added intangible costs that Congress, in 1982 and again in 1983, found certain TEFRA hospitals (and all DSHs under Medicaid) must incur in treating such patients. Furthermore, the Court's acceptance of the notion that the supposedly "cost-based" TEFRA system already accounts for such added costs, at least to the extent that a hospital's proportion of low-income patients does not increase from its base year, simply ignores the conclusion that a DSA is necessary, even under TEFRA, to "take into account the special needs of psychiatric hospitals" and others that serve a disproportionate number of low-income patients.

Yet, at that time it was known that the DRG system, on which PPS is based, could not effectively accommodate, *inter alia*, psychiatric diagnoses. Ironically, the fact that Congress added DSA to section 1395f(b)(2) in 1984, and agreed, finally in 1986, to force the Secretary to pay DSAs to PPS hospitals and, in 1988 to hospitals under Medicaid, memorializes the original admonishments in the 1982 TEFRA.[13]

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13. The Circuit Court's recognition (52 F.3d at 1172) that poorer patients may incur additional costs and could have that adjustment made under section 1395ww(b)(4)(A), citing Regulation Section 413.40(g)(3)(ii)(D)(1993) ignores (g)(3)(iii) which excludes (D) as recourse. However, this is totally irrelevant since it was Congress' finding of the definition of a DSH and not the hospital's burden to show (other than by tallying numbers of its low-income patients), that is the predicate for a DSA.

Of course, there is the additional question of the validity of the basic premise that 1982 costs adjusted by an API that, as the District Court put it "bear little or no relation to reasonable and necessary actual costs" (Rye, 846 F. Supp. at 1182), can be said even to approximate fair compensation in 1995. Also, the fact that the Secretary insists on "compounding" the APIs for such TEFRA hospitals appears to be much more of a token gesture than one statutorily indicated. Compare subparagraphs 42 U.S.C. § 1395ww(b)(3)(A),(C),(D),(E).

C. Case Mix Includes DSA

The Secretary's interpretation of the statutory term "case mix," as excluding a DSA, embraced by the Court of Appeals, incorrectly distinguishes the "medical" and "financial" conditions of patients. 52 F.3d at 1170-71. The opinion below states, "[a] reading of Section 1395ww in its entirety demonstrates that the term "case mix" used in Section 1395ww(b)(4)(A) refers to the medical condition of a hospital's patients, not to their financial circumstances. " 52 F.3d at 1170. But the DSA also refers to the medical condition of patients, as the Court below recognized. "The existence of the DSA is attributable to Congress's conclusion that low-income patients tend to be in poorer health, and therefore to cost more to treat than others." *Id.* at 1171. As Congress found that fair reimbursement for the measurable cost and the actuarially derived intangible cost of intensity of illness is the objective of the Medicare reimbursement system, it must be the combined cost of treating a disproportionate mix of poorer patients that is the relevant inquiry. That is why "operating costs of inpatient hospital services" in 1982 were defined as to be determined on an average per admission or discharge basis for TEFRA hospitals (42 U. S.C. § 1395ww(a)(4)), with the DSA of (a)(2)(B) or 42 U.S.C. § 1395(b)(2) to be added to that average pursuant to 42 U.S.C. § 1395ww(b)(4)(A).

Accordingly, unless the term "case mix" in (b)(4)(A) is given the meaning that includes all medical conditions that affect cost, it is robbed of much of its meaning. Put another way, it is not the financial condition of patients that is measured by "case mix," but the costs, tangible and intangible, to treat disproportionately large numbers of medical conditions including those of persons who are more acutely ill because they have low income.

"Case mix" is not a term of art with a precise definition and, depending upon the context in which it is used, can have a variety of meanings. Had Congress intended the crimped meaning ascribed by the Secretary and the Court below, one would expect to find some expression of that intent. There is no such expression. It well may be that where the term was used in the context of PPS it meant the mix of what came to be DRGs. However, two of the three cases cited by the court below also reflect a less restrictive meaning — even in the PPS context. *Massachusetts Fed'n of Nursing Homes, Inc. v. Massachusetts,* 772 F. Supp. 31, 33 (D. Mass. 1991), ("'case mix' refers to patients' levels of sickness or acuity"; *New Jersey Ass'n of Health Care Facilities, Inc. v. Gibbs,* 838 F. Supp. 881, 912 (D.N.J. 1993) ("systems that calculate reimbursement on the basis of medical acuities and ADLs [activities of daily living] are generally referred to as 'case mix' systems"). Neither of those definitions is limited to a description of the "mix" of DRGs. Those essentially define specific illnesses, not their relative severity. "Acuity" means "sharpness; acuteness; keenness." The Random House Dictionary of the English Language 15 (unabridged ed. 1971). Apparently, at the time TEFRA was enacted, the Secretary had a significantly different view of case mix than she espouses today ("under the new system each hospital's limit will be adjusted by a case-mix index that is specific to the hospital"). 47 Fed. Reg. 43285 (1982).

The variations in these definitions illustrate the variety of

possible meanings. However, none are inconsistent with consideration of severity of illness. The congressional knowledge that poorer patients are sicker, thereby requiring an actuarial formulation of a DSA, does not change the fact that it is the severity of illness, not poverty, that is being treated and recognized by the DSA. To read remedial legislation as narrowly as does the Secretary and the Court below, saps the relevant congressional recognition of the context of the Social Security Act of all meaning.

Thus, the statement in the opinion below that "the language of Section 1395ww (a)(l)(B)(i) makes it reasonably plain that 'case mix' refers to the mix of medical rather than financial conditions ofthe patients," 52 F.3d at 1171, though true, especially in the context of that particular provision, is inapposite here. "Case mix," in that clause could only have been applied to the PPS hospitals-to-be because only they treated patients with conditions confidently identified by DRGs and thus, could have developed indexes. However, when used in a subsection which generally is agreed to have no application to the DRG system ((b)(4)(A)), the term obviously must have its broader meaning.[14]

The last case cited in the opinion below on this point, *Multicare Medical Center v. Washington,* 768 F. Supp. 1349, 1361-62 and n.3 (W.D. Wash. 1991), uses the term in a more technical sense in describing a DRG system. "The term 'case-mix' refers to the average relative weight of the cases that a hospital treats." TEFRA hospitals do not have "relative weights" or any of the accouterments of the PPS (including, regrettably, the various adjustments through which PPS reimbursement rates are regularly modified upwards for relevant factors). So if the adjustment for changes in case mix required by (b)(4)(A) is to

14. Note the use of the singular form "hospital's" in the mandatory sentence of (b)(4)(A), directing the Secretary to adjust a hospital-specific rate. Such a rate no longer exists in the PPS.

have meaning at all, it must include an adjustment for a hospital treating a large number of poorer, thus sicker patients, *i.e.*, a DSA.

In a footnote, the Court below observes that, "[i]n any case, Section 1395 [sic](a)(2) required the Secretary to make only such provision [for DSA] as the Secretary 'deems necessary.' The Secretary's judgment that no such provision is necessary is entitled to substantial deference." 52 F.3d at 1170 n.6 (citing *Chevron U.S.A., Inc.*, 467 U.S. at 843-45). This overlooks the history recounted above which demonstrates that what Congress commanded, the Secretary took merely as a suggestion and ignored, because she did not "deem" that any DSA is warranted. 50 Fed. Reg. 53398, 53399 (1985). Even the congressional command in subsection (a)(2): "The Secretary shall... (section 1395ww(a)(2))" gives deference only to methodology — to "how," not to "whether."

Indeed, years after Congress finally took matters into its own hands and implemented the DSA, the Office of Inspector General ("OIG"), acting under the Secretary's authority, perseveratively stated that the OIG and HCFA both agree that DSA payments "are unnecessary" and that provisions for such adjustments should be repealed. The OIG report states: "HCFA officials agreed with the results of our analysis, however they did not believe that Congress would be receptive to the total repeal of [DSA]." *Report on Disproportionate Share Payments to Hospitals Under PPS*, May 3, 1988, reprinted at Medicare & Medicaid Guide (CCH) ¶ 37, 105 at 16,968-16, 973. HCFA's belief was based upon the fact that Congress had "recently enacted legislation extending and expanding the [DSA] payment provisions [which used, for Medicaid, the Medicare formulae found in section 1395ww(d)(5(F)]." *Id.* at 16,973. 42 U.S.C. § 1396r-4. History shows that Congress did not defer to the Secretary's suggestion.

In *Jewish Hosp. Inc. v. Secretary of Health and Human Services,* 19 F.3d 270, 272, 276 (6th Cir. 1994) the Court of Appeals for the Sixth Circuit criticized the Secretary's "restrictive reading of the disproportionate share adjustment" and found the "contention that the Secretary was hostile to the concept of disproportionate share adjustment credible and compelling."

The Secretary emphasized, and the District Court here noted, that because the target section opens with: "Notwithstanding section 1395f(b) . . ." [as did subsection (d)(l)(A) in 1983] (42 U.S.C. § 1395ww(b)(1), (d)(1)), it was intended by Congress to exclude all payments above the target, even though they were in conformity with the allowable-cost section 1395x(v)(1)(A) limits. Yet, in 1982, the Secretary stated that her understanding of the reason for the phrase "[n]otwithstanding section 1395f(b) . . ." was only that payments were to be "made without regard to the provisions of section 1814(b) [42 U.S.C. § 1395f(b)] which requires payment of charges when they are lower than costs." 47 F. Reg. at 43283 (1982). Congress had made section 1395f(b), with its "reasonable costs or customary charges" provision, subject to the entire section 1395ww in 1982. Pub. L. 97-248 § 101(c)(1), 42 U.S.C.A. § 1395f(b) (1992). In 1983, however, Congress enacted the present subsection (d), replacing the former subsection (d) "lesser of costs or charges" provision and moved it to subsection (j) of section 1395f. Thus, congressional intent in its enactment in 1984 adding DSA to section 1395f(b)(2), demonstrated only its intent for all TEFRA hospitals to have DSAs (subject to subsection (b)(4)(A)).

As this Court has explained, "[t]he judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent." *Chevron,* 467 U.S. at 843 n.9; *Georgetown*

University Hosp. v. Bowen, 862 F.2d 323, 326 (D.C. Cir. 1988) ("[O]ur inquiry into congressional intent must encompass both the particular language, as well as the broader design of the statute"). With *Chevron*, the question of whether the Secretary's interpretation is based on a permissible construction of the statute, as relied upon by the court below, arises only where Congress did not directly address the precise question at issue, either due to silence or ambiguity. *Chevron*, 467 U.S. at 843. If, as in *Chevron*, the statute is unclear, the next analytic move for the judiciary is not a leap to Executive deference but a step to legislative history. In addition, it makes no sense to defer to an agency judgment on how a statute should be interpreted and implemented when that agency has demonstrated continuous, implacable resistance to the statutory scheme itself. This is especially true where, as in this case, Congress had just acted to abrogate the deferential authority it unavailingly had delegated to the Secretary to formulate a standard for DSH adjustments.

The Secretary's well-documented hostility to Congress's DSA program should put to rest any idea that her contemporaneous construction must be granted deference or that Congress intended to leave any ambiguity for the Secretary to resolve. For that to be the case, there would be no need for Article III of the Constitution. At a minimum, the Secretary's refractoriness should cause this Court to view her claim to deference with extreme skepticism.

The Court is the final authority on statutory construction. *See Federal Election Comm'r v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27 (1981) and *Oregon Ass'n of Hospitals v. Bowen*, 708 F.Supp. 1135, 1138 (D.Or. 1989). Where deference to an agency is appropriate, such deference does not mean acquiescence. *Presley v. Etowah County Comm'n*, 502 U.S. 491(1992). And where deference to the agency is not warranted, as is true here, only the courts have the legitimate power to decide

whether the agency has properly implemented the statutory scheme based on legislative intent. Congress intended that the DSA be made by the Secretary to those hospitals meeting the qualifying definition. That is what the District Court found, too.

It follows that Congress intended no distinction in this regard between TEFRA and PPS hospitals since both groups treat the same beneficiaries of the Social Security Act. The creation of one by the Secretary and the stamp of approval thereon by the Court of Appeals results in a denial of equal protection under the Constitution.

CONCLUSION

For the reasons stated in the foregoing, petitioner respectfully submits that the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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APPENDIX A — JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT FILED APRIL 10, 1995

UNITED STATES COURT OF APPEALS
FOR THE
SECOND CIRCUIT

At a stated term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the 10th day of April, one thousand nine hundred and ninety-five.

PRESENT: HONORABLE JON O. NEWMAN
Chief Judge,
HONORABLE ROGER J. MINER,
Circuit Judge,
HONORABLE LEWIS A. KAPLAN,
District Judge*

RYE PSYCHIATRIC HOSPITAL CENTER, INC.,

Plaintiff-Appellee-
Cross-Appellant,

v.

DONNA E. SHALALA, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendant-Appellant-
Cross-Appellee.

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* Of the United States District Court for the Southern District of New York, sitting by designation.

Appendix A

Appeal from the United States District Court for the Southern District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Southern District of New York and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby ORDERED, ADJUDGED, and DECREED that the judgment of the District Court is affirmed in part, reversed in part and remanded to said District Court for further proceedings in accordance with the opinion of this Court.

GEORGE LANGE III, Clerk
By:

s/ Arthur Heller,
Arthur Heller,
Administrative Attorney

[Stamped]
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GEORGE LANGE III, CLERK
s/ George Lange III

APPENDIX B — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT REPORTED AT 52 F.3d 1163

RYE PSYCHIATRIC HOSPITAL CENTER, INC.,

Plaintiff-Appellee-
Cross Appellant,

v.

Donna E. SHALALA, Secretary, United States Department of Health and Human Services,

Defendant-Appellant-
Cross Appellee.

Nos. 921,1253, Dockets 946172, 946198.

United States Court of Appeals,
Second Circuit.

Argued Jan. 20, 1995.

Decided April 10, 1995.

Psychiatric hospital brought action against Secretary of Health and Human Services (HHS) seeking adjustment of reimbursement rate for charges covering Medicare patients. The United States District Court for the Southern District of New York, Charles L. Brieant, J., 846 F. Supp. 1170, entered judgment from which appeal and cross-appeal were taken. The Court of Appeal, Kaplan, District Judge, sitting by designation, held that: (1) "Disproportionate Share Adjustment" (DSA) available to hospitals under the prospective payment system (PPS) that treat disproportionate number of low-income patients was not

available to psychiatric hospital, reimbursed under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); (2) DSA provision was not in substance incorporated into TEFRA reimbursement statute by provision for adjustment based on changes in "case mix," as term refers to medical condition of hospital's patients, not to their financial circumstances; (3) applicable statute was not unconstitutional on its face as denying psychiatric hospital equal protection; and (4) claim that statute and regulations were unconstitutional as applied with respect to any given reimbursement was not ripe.

Affirmed in part, reversed in part, and remanded.

* * *

Frederick A. Nicoll, New York City, for plaintiff-appellee-cross appellant.

Nancy L. Savitt, Asst. U.S. Atty. S.D.N.Y., (Mary Jo White, U.S. Atty., Steven M. Haber, Asst. U.S. Atty. S.D.N.Y., of counsel), for defendant-appellant-cross appellee.

Before: NEWMAN, Chief Judge, MINER, Circuit Judge, and KAPLAN, District Judge.*

KAPLAN, District Judge.

Since the 1960s, the Social Security Act's Medicare provisions, 42 U.S.C. §§ 1395-1395ccc (1988) ("Medicare"), have reimbursed hospitals and other providers for many of the

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* Lewis A. Kaplan, United States District Judge for the Southern District of New York, sitting by designation.

costs of medical care provided to qualifying persons. This case concerns the relationship between two of the hospital cost reimbursement provisions of Medicare.

The prospective payment system ("PPS"), established pursuant to the Social Security Amendments of 1983, requires the Secretary of the Department of Health and Human Services (the "Secretary") to increase payments to hospitals covered by PPS that treat a disproportionate number of low-income patients (the "Disproportionate Share Adjustment" or "DSA"). 42 U.S.C. § 1395ww(d)(5)(F). This reflects a Congressional judgment that low-income patients frequently are in poorer health, and therefore cost more to treat, than others.[1] Given the structure of the PPS reimbursement system, which bases reimbursement on national and regional average costs for the treatment of particular diseases, the lack of such an adjustment would penalize hospitals treating disproportionate numbers of low-income patients.

Plaintiff Rye Psychiatric Hospital Center, Inc. ("Rye") is not subject to PPS. Its Medicare reimbursements are governed instead by provisions first enacted in the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"). Unlike PPS, the structure of the TEFRA reimbursement system takes into account the presumptively higher cost of treating low-income patients in setting the base reimbursement rate. Thus, while TEFRA provides for adjustment in the reimbursement rates paid to Rye and other TEFRA hospitals for distortions caused by ***1165** events beyond their control or by extraordinary circumstances, 42 U.S.C. § 1395ww(b)(4)(A), it does not contain a DSA, i.e., a

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1. See H.R.Conf.Rep. No. 861, 98th Cong., 2d Sess. 1356 (1984), reprinted in 1984 U.S.C.C.A.N. 1445, 2044; S.Rep. No. 23, 98th Cong., 1st Sess. 54 (1983), reprinted in 1983 U.S.C.C.A.N. 143, 194; Samaritan Health Center v. Heckler, 636 F.Supp. 503, 508 (D.D.C.1985).

required adjustment based solely on the proportion of low-income patients treated. Accordingly, a regulation adopted by the Secretary limits DSAs to hospitals that are subject to PPS. See 42 C.F.R. § 412.106(a)(1)(ii) (1993) (limiting consideration to "patient days attributable to areas of the hospital that are subject to [PPS] and exclud[ing] all others").

Rye brought this action for, inter alia, a declaration that the regulation excluding TEFRA hospitals from receiving DSAs conflicts with the statute — in other words, that the statute entitles Rye to a DSA — or, alternatively, that the statute deprives Rye of the equal protection of the laws. The District Court, on cross-motions for summary judgment, rejected Rye's contention that 42 U.S.C. §1395ww(d)(5)(F) requires payment of the DSA to Rye. It nevertheless ruled that the adjustment provision of TEFRA, 42 U.S.C. § 1395ww(b)(4)(A), which requires the Secretary to adjust reimbursements to Rye and other TEFRA hospitals where changes in "the case mix of such hospital[s]," among other factors, create a distortion in cost increases, compels the Secretary to adjust reimbursements to Rye on substantially the same basis as if Section 1395ww(d)(5)(F) applied directly. Rye Psychiatric Hospital Center, Inc. v. Shalala, 846 F.Supp. 1170 (S.D.N.Y. 1994). It did so on the theory that the term "case mix" in 42 U.S.C. § 1395ww(b)(4)(A) "includes the concept of a 'significantly disproportionate number of low-income patients' as defined in 42 U.S.C. § 1395ww(d)(5)(F)."

The Secretary appeals from the declaration requiring application of the substance of the DSA under Section 1395ww(b)(4)(A). Rye cross-appeals from the District Court's determination that Section 1395ww(d)(5)(F) does not directly require payment of the DSA to Rye.

Appendix B

The District Court correctly held that Section 1395ww(d)(5)(F) does not require payment of the DSA to TEFRA hospitals like Rye. Its conclusion that the Secretary is obliged to apply the substance of the DSA under Section 1395ww(b)(4)(A), however, fails to give due regard to either the statutory language or the fundamentally different structures of the TEFRA and PPS reimbursement systems. Indeed, a DSA in the context of the TEFRA reimbursement system is unnecessary to take appropriate account of the higher cost of treating low-income patients and, in some circumstances, would lead to overreimbursement. Rye's constitutional challenges are without merit. Accordingly, we affirm the District Court's holding that Rye is not entitled to a Disproportionate Share Adjustment under Section 1395ww(d)(5)(F). We reverse the determination that the Secretary is obliged by Section 1395ww(b)(4)(A) to adjust reimbursement rates based solely on the proportion of low-income patients served by a TEFRA hospital.

Statutory and Regulatory Framework

The Original Reasonable Cost System

At its inception, Medicare reimbursed hospitals primarily through a retrospective, reasonable cost system. At the end of each fiscal year, hospitals reported the total costs for which they sought reimbursement. These were subject to audit. See generally Tucson Medical Center v. Sullivan, 947 F.2d 971, 973-74 (D.C.Cir.1991). Reimbursement was limited to reasonable or necessary charges. 42 U.S.C. § 1395f(b)(1) (1988). The Secretary was given broad discretion to eliminate costs "unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A) (1988).

Appendix B

The reasonable cost system, Congress soon concluded, did not provide hospitals with sufficient incentives to be efficient. Because the reasonable cost system was an actual cost system, "[t]he more [hospitals] spent, the more they were reimbursed." Tucson Medical Center, 947 F.2d at 974. In consequence, Congress in 1972 authorized the Secretary to impose prospective limits on certain costs. Social Security Amendments of 1972, Pub.L. No. 92-603, § 223(b), 86 Stat. 1329, 1393 (1972). The Secretary thereupon established a schedule of reimbursable and non-reimbursable expenses in 1974. See 42 C.F.R. § 413.30 (1993).

***1166** The TEFRA System

By the early 1980s, Congress concluded that the reasonable cost system, even supplemented by the Secretary's schedule, did not curb costs sufficiently and sought more control. Its first step was the enactment in 1982 of the TEFRA reimbursement system, which was intended to remain in effect for up to three years while the Secretary developed a prospective reimbursement system. Tucson Medical Center, 947 F.2d at 974-75; Pub.L. No. 97-248, 96 Stat. 324 (1982), codified in 42 U.S.C. § 1395ww(b) (1988). Although most hospitals now are covered by the PPS, which became effective in 1983, Rye still is covered by TEFRA for reasons discussed below.

The initial step in fixing a TEFRA hospital's entitlement to reimbursement, generally speaking, is to determine its total "allowable costs" for a base year. 42 C.F.R. § 413.40(b)(1) (1993); Tucson Medical Center, 947 F.2d at 975. Reimbursements in subsequent years, however, do not depend on total or allowable costs incurred in those subsequent years. Rather, a maximum permissible reimbursement, or "target

amount," for each subsequent period is established by multiplying the figure for the base year by a legislatively determined percentage.[2] 42 U.S.C. § 1395ww(b)(3) (1988); 42 C.F.R. § 413.40 (1993). If a hospital expends more than its target amount, or ceiling, it is reimbursed only up to the amount of the ceiling. If its costs are less than its ceiling, it is given a bonus payment of half the difference between its costs and the ceiling. 42 U.S.C. § 1395ww(b)(1)(A) (1988); 42 C.F.R. § 413.40 (1993); see generally Connecticut Hospital Association v. Weicker, 46 F.3d 211, 214-15 (2d Cir.1995) (hereinafter "CHA").

Absent successful application for an adjustment, as outlined below, the target amount so determined is the maximum Medicare reimbursement that a TEFRA hospital may receive for any given year. How fully a TEFRA hospital is reimbursed from year to year thus depends on (1) how representative its base period is of its actual total costs in the relevant year, and (2) how closely the Congressionally fixed percentage increase mirrors any increase in the hospital's costs. If a hospital's actual total costs equal its costs in the base period plus the statutory increase, it will be fully reimbursed. If a TEFRA hospital's actual total costs in any given year differ from the costs in the base period plus the statutory increase, however, its reimbursement may either fall short of or exceed its actual total costs. Thus, TEFRA seeks to reward hospitals that spend less than the target amounts and penalize those that spend more.

Congress recognized that a variety of circumstances might prevent the target amount from reflecting fairly the costs for which a hospital should be reimbursed. TEFRA therefore allows

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2. The statutory percentages used to calculate the target rates are intended to reflect primarily cost increases attributable to inflation. See 56 Fed.Reg. 43,229 (Aug. 30, 1991).

for adjusting reimbursement amounts "where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period. . . ." 42 U.S.C. § 1395ww(b)(4)(A) (1988). See generally CHA, 46 F.3d at 214-15. The regulations adopted under Section 1395ww(b)(4)(A) permit two types of adjustments.

Under 42 C.F.R. § 413.40(g), the Secretary may adjust the amount of operating costs considered in establishing the ceiling, including both the base period and any subsequent period, to take account of (1) extraordinary events such as fires, floods, strikes and other events that might increase costs, and (2) certain economic changes that might distort operating costs between the base year and the year in which a particular cost ceiling is imposed. For example, under 42 C.F.R. § 413.40(g)(3)(ii)(D) (1993), an "[i]ncrease[ ] in service intensity or length of stay attributable to changes in the type of patient served" compared with the base period is a basis for an adjustment.

Section 413.40(i) of the regulation, which applies to years beginning after 1990, permits the Secretary to assign a new base period if, among other things, the new base period is more representative of the costs of providing services as a result of substantial and permanent changes in furnishing care. *1167 Because the base period is the starting point for the determination of all subsequent ceilings, changing the base period affects all future target amount calculations of the hospital, not merely that of a particular year.[3]

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3. As TEFRA's yearly percentage increases in reimbursement are set by statute, 42 U.S.C. § 1395ww(b)(1)(B)(i) (1988), the Secretary may not adjust them to bring reimbursement more in line with actual costs.

Appendix B

Reimbursement and adjustment for TEFRA hospitals such as Rye occurs every twelve months following a hospital's submission of a summary of the past year's costs to a fiscal intermediary. See 42 C.F.R. §§ 405.1801(b)(1), 413.24(f) (1993). The intermediary reviews the report to determine what part of the claim is reimbursable under the statute and regulations and then issues a "notice of program reimbursement," or "NPR," which sets forth the final payment for the year. Tucson Medical Center, 947 F.2d at 974.

The hospital may claim an adjustment either in its initial submission to the intermediary or within 180 days after the NPR is issued. An intermediary, unless authorized by the Health Care Financing Administration ("HCFA"), cannot rule on the adjustment request. It instead must send the request to HCFA for review. 42 C.F.R. § 413.40(e) (1993).

After receiving a final decision on reimbursement and adjustments, the hospital may appeal to the Provider Reimbursement Review Board (the "Board"), an administrative body established to hear such challenges, and ultimately to an appropriate District Court. 42 U.S.C. §§ 1395oo(a), 1395oo(f)(1) (1988); 42 C.F.R. §§ 405.1835, 405.1875 (1993). If the Board determines that an issue raised is one that the Board lacks authority to decide, such as the validity of a regulation, the hospital may seek immediate judicial review of the question. 42 U.S.C. § 1395oo(f)(1) (1988).

The Prospective Payment System

The PPS marked a major departure in Medicare reimbursement policy. It established a number of Diagnostically Related Groups ("DRGs"), which describe particular classes of

patients and treatments, and the amount Medicare will pay for each. DRG cost schedules are generated from anticipated national and regional average costs for the treatment of particular illnesses. 42 U.S.C. § 1395ww(d)(2)(D) (1983).[4]

This system differs substantially from TEFRA. In focusing on national and regional averages for the cost of treating particular illnesses, it is not based on the cost to any particular hospital of treating particular DRG-classified illnesses.

The PPS uses two methods to deal with costs not adequately captured by the DRGs. First, a number of illnesses and treatments, including psychiatric care, are regarded as so inherently unpredictable that they cannot be categorized adequately within the DRG system. 56 Fed.Reg. 43,232 (1991). Hospitals or units of hospitals that treat such illnesses, like Rye, therefore are excluded from the PPS and instead continue to be reimbursed under TEFRA, which is based on the hospitals' past costs and does not require classification of patients into illness-based DRGs. See 42 U.S.C. §§ 1395ww(b), 1395ww(d)(1)(B) (1988); 42 C.F.R. §§ 412.20(b)-412.30 (1993).

Second, the PPS statute and regulations contain a number of adjustment provisions, only one of which, 42 U.S.C. § 1395ww(d)(5)(F) (1993), is at issue in this case. Section 1395ww(d)(5)(F), so far as relevant here, requires an additional payment per patient discharge for hospitals serving a

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4. The PPS seeks to promote efficiency by permitting hospitals to keep the difference between actual costs and the DRG amount, and by denying hospitals payment for costs over the DRG amount. See H.R.Rep. No. 25, 98th Cong., 1st Sess. 132 (1983), reprinted in 1983 U.S.C.C.A.N. 219, 351; S.Rep. No. 23, 98th Cong., 1st Sess. 47 (1983), reprinted in 1983 U.S.C.C.A.N. 143, 187.

significantly disproportionate number of low-income patients.[5] A hospital is deemed to serve a significantly disproportionate number *1168 of low-income patients if the proportion of its total patient days consisting of patient days attributable to low-income patients exceeds specified percentage criteria, e.g., fifteen percent if the hospital is located in an urban area and has one hundred or more beds. Id. § 1395ww(d)(5)(F)(v)-(vi). As we have noted, this Disproportionate Share Adjustment provision reflects Congress' determination that DRG payments, which are based on national and regional average costs for particular illnesses, do not adequately reflect the added costs of treating low-income patients, who tend to be sicker and more costly to treat than the average.

Administrative Proceedings

Rye is a private psychiatric hospital reimbursed under TEFRA. 42 U.S.C. § 1395ww(d)(1)(B) (1988). In 1992, it requested the Board to determine that the Board lacked authority to decide, among other things, whether 42 C.F.R. § 412.106 incorrectly interpreted 42 U.S.C. § 1395ww by excluding certain PPS-exempt hospitals from receiving the Section 1395ww(d)(5)(F) DSA or, alternatively, whether the statute deprived those hospitals of due process of law. Such a determination was a precondition to Rye's right to seek judicial review. 42 U.S.C. § 1395oo(f)(l) (1988); 42 U.S.C. § 405(h) as incorporated by 42 U.S.C. § 1395ii (1988). On May 8, 1992, the Board made the requested determination and granted Rye's

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5. Under this scheme, a low income patient is one who either receives both Medicare Part A and supplemental security income benefits, or receives both Medicaid and Medicare. 42 U.S.C. § 1395ww(d)(5)(F)(iv)-(viii) (1988); 42 CFR § 412.106(b)(2) (1993).

request for expedited judicial review. This case followed shortly thereafter.

Discussion
The DSA Does Not Apply to PPS-Exempt Hospitals

Although the question is posed by the cross-appeal as a result of the sequence in which the notices of appeal were filed, we view the question whether the DSA established by Section 1395ww(d)(5)(F) applies to Rye and other PPS-exempt hospitals as the logical starting point for analysis.

Clause (i) of Section 1395ww(d)(5)(F) provides:

> For discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which — (I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or meets certain other criteria. (Emphasis added). Clauses (ii) through (viii) proceed to set forth the formula for determining the additional payment (clause ii), define a term used in making that determination (clauses iii and iv), define a hospital that "serves a significantly disproportionate number of low-income patients" (clause v), define a term used in clause v (clause vi), and set forth two formulae relevant to two subsets of the hospitals to which subparagraph (F) applies

> (clauses vii and viii). Thus, the question whether the DSA is available under Section 1395ww(d)(5)(F) to a particular hospital turns on whether it is a "subsection (d) hospital."

Section 1395ww(d)(1)(B) states in relevant part:

> As used in this section, the term 'subsection (d) hospital' means a hospital located in one of the fifty States or the District of Columbia other than —
>
> (i) a psychiatric hospital (as defined in section 1395x(f) of this title).

Since it is undisputed that Rye is a psychiatric hospital as defined in Section 1395x(f), Rye is not a "subsection (d) hospital" and therefore is not entitled to the DSA under Section 1395ww(d)(5)(F). Moreover, as the District Court held, 846 F.Supp. at 1180, and as Rye concedes (Rye Br. 38), the Secretary's regulations specifically exclude PPS-exempt hospitals. 42 C.F.R. § 412.106 (1993); accord, 53 Fed.Reg. 38476, 38480 (Sept. 30, 1988). As the official charged with administering this complex program, her interpretation is controlling unless it is unreasonable. See, e.g., Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 843-45, 104 S.Ct. 2778, 2782-83, 81 L.Ed.2d 694 (1984); see also CHA, 46 F.3d at 219. On the basis of the statutory language described above and the role of the DSA in the statutory scheme, discussed below, there is no basis for rejecting her interpretation.

***1169** Rye disputes this conclusion on two bases. Each is without merit.

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Rye first argues that the reference in Section 1395ww(d)(5)(F)(i) to "subsection (d) hospital[s]" does not prevent payment of the DSA to Rye despite the fact that Rye concededly is not a subsection (d) hospital. Section 1395ww(d)(5)(F)(iv) defines the term "disproportionate share adjustment percentage" for hospitals that are "not described in clause (i)(II)" and that meet certain additional criteria. Rye's argument seems to be that Rye is not a hospital described in Section 1395ww(d)(5)(F)(i)(II) and, in consequence, that it gets the benefit of Section 1395ww(d)(5)(F)(iv). There are at least two problems with the argument.

To begin with, the argument ignores the structure of Section 1395ww(d)(5)(F). Clause (i) states that the additional DSA payments are to be made only to "subsection (d) hospitals." It then identifies in subclauses (i)(I) and (i)(II) two groups of subsection (d) hospitals. Thus, subclauses (i)(I) and (i)(II) both are subsets of clause (i). The disproportionate share adjustment percentages for these two groups of subsection (d) hospitals are set out in clauses (iii) and (iv) respectively. Thus, there is no basis in the text for Rye's contention that hospitals which are not subsection (d) hospitals are entitled to the DSA under Section 1395ww(d)(5)(F). Put another way, all of Section 1395ww(d)(5)(F) is limited to subsection (d) hospitals.

The argument also neglects the substance of Section 1395ww(d)(5)(F)(iv). That clause does no more than define the term "disproportionate share adjustment percentage" for subsection (d) hospitals described in clause (i)(II). The term is used in computing the additional amounts payable pursuant to clause (i), which are payable only to subsection (d) hospitals. In consequence, even if Rye somehow fell within clause (iv), it would not be entitled to any additional payment because it does not fall within clause (i).

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Rye seems to argue also that 42 U.S.C. § 1395ww(a) (1988) requires payment of the DSA to TEFRA as well as PPS hospitals. The basis of the argument is the following language in subparagraph (2):

> The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account —
>
> * * * * * *
>
> (B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low-income or are entitled to benefits under part A of this subchapter.

The difficulty with the argument, however, is that it tears this language from context.

Sections 1395ww(a)-(c) were enacted in 1982 by Section 101(a)(1) of the Tax Equity and Fiscal Responsibility Act, which also established the TEFRA reimbursement system and directed the Secretary to develop a prospective payment system and led to the enactment of PPS. Pub.L. 97-248, § 101(a)(1), 96 Stat. 331-35 (1982). They were part of an expansion of then-existing reimbursement restrictions known as Section 223 limits. H.R.Conf.Rep. No. 760, 97th Cong., 2d Sess. 417-18 (1982), reprinted in 1982 U.S.C.C.A.N. 1190, 1198.

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Subparagraph (A) of Section 1395ww(a)(1) provides in substance that the Secretary is prohibited from recognizing as reasonable costs which exceed the average for similar groupings of hospitals by stipulated percentages. Subparagraph (B) directs the Secretary to establish case mix indices for short-term hospitals and to set limits for each hospital based upon the general mix of types of medical cases for which it provides services. Subparagraph (C) provides in substance that the costs recognized as reasonable prior to the enactment of this statute set a floor under the costs that were to be recognized as reasonable. Subparagraph (D) provides that subparagraph (A) would not apply to reporting periods beginning after October 1, 1983. Thus, the cost limits established in Section 1395ww(a)(1)(A) have not applied to new reporting periods for many years.

***1170** Section 1395ww(a)(2), upon which Rye relies, and (a)(3) both explicitly provide for exceptions to the limitations established by Section 1395ww(a)(1)(A). In other words, Section 1395ww(a)(2)(B) directs the Secretary to take into account, to the extent she deemed necessary, "the special needs of psychiatric hospitals . . . that serve a significantly disproportionate number of" low-income patients in making exceptions to the 1395ww(a)(1)(A) cost limits. As the Section 1395ww(a)(1)(A) cost limits do not apply to periods beginning on or after October 1, 1983, Sections 1395ww(a)(2) and, for that matter, (a)(3) have no bearing with respect to such periods and thus no bearing on Rye's right to reimbursement in any period relevant here.[6]

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6. In any case, section 1395(a)(2) required the secretary to make only such provision as the Secretary "deems necessary." The Secretary's judgment that no such provision is necessary is entitled to substantial deference. See, e.g., Chevron, U.S.A., Inc., 467 U.S. at 843-45, 104 S. Ct. at 2782-83. As we explain below, the Secretarys conclusion that no reimbursement adjustment based solely on the proportion of low income patients is warranted is not unreasonable.

Accordingly, the District Court correctly held that Rye is not entitled to a Disproportionate Share Adjustment pursuant to 42 U.S.C. § 1395ww(d)(5)(F).

The "Case Mix" Adjustment Does Not Include the DSA

This brings us to the Secretary's contention that the District Court erred in holding that Section 1395ww(b)(4)(A) in substance incorporates the DSA on the ground that the term " 'case mix' includes the concept of a 'significant disproportionate number of low-income patients' as defined in 42 U.S.C. § 1395ww(d)(5)(F)." 846 F.Supp. at 1182.

As noted above, Section 1395ww(b)(4)(A) provides in relevant part that the Secretary shall adjust reimbursements "where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period. . . ." 42 U.S.C. §1395ww(b)(4)(A) (1988).

The District Court reasoned that this provision "modifies all other statutory provisions and regulations under them" and, in consequence, that "none of the regulations can be read to impose unreasonable restrictions on reimbursement for medically necessary services provided to qualified Medicare beneficiaries. . . ." 846 F.Supp. at 1182. It evidently accepted Rye's view that the lack of a DSA for TEFRA hospitals unreasonably would deprive such hospitals of reimbursement for the presumptively higher costs of treating low-income patients, for it concluded that Section 1395ww(b)(4)(A) "deals in different language with the same factual problem of a substantial proportion of low-income patients." Id. at 1183. Based on that premise, it held that the term "case mix" in that section "includes the concept of 'significant disproportionate number of low-

income patients.' " Id. Accordingly, the judgment declared that the Secretary must consider the treatment of a disproportionate number of low-income patients in determining whether Rye is entitled to an adjustment based on a change in its case mix. We conclude that this was error.

We begin with the fact that the statute manifestly distinguishes between adjustments based in "case mix" changes and those based on the existence of a disproportionate share of low-income patients. Compare 42 U.S.C. § 1395ww(b)(4)(A) with id. § 1395ww(d)(5)(F). A reading of Section 1395ww in its entirety demonstrates that the term "case mix" used in Section 1395ww(b)(4)(A) refers to the medical condition of a hospital's patients, not to their financial circumstances.

As we have noted, Section 1395ww(a)(1)(A) established reimbursement ceilings as part of the expansion of the Section 223 limits. Section 1395ww(a)(1)(B)(i) provides:

> For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this subchapter. (Emphasis added).

*1171 Thus, the language of Section 1395ww(a)(1)(B)(i) makes it reasonably plain that "case mix" refers to the mix of medical rather than financial conditions of the patients.[7]

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7. See also Massachusetts Federation of Nursing Homes, Inc. v. Massachusetts, 772 F.Supp. 31, 33 (D.Mass.1991); New Jersey Ass'n of Health (Cont'd)

Appendix B

Our view is confirmed by Section 1395ww(a)(2), which we have discussed already in rejecting Rye's argument that Section 1395ww(a) requires payment of the DSA to TEFRA as well as PPS hospitals. Ante, at 1170. Concerned that the reimbursement limits enacted in 1982 in Section 1395ww(a)(1)(A) might have an adverse impact on hospitals serving a disproportionate share of low-income patients, Congress provided in Section 1395ww(a)(2)(B) that the Secretary should make such exemptions and adjustments as the Secretary deemed necessary to accommodate "the special needs of . . . hospitals that serve a significantly disproportionate number of patients who have low-income. . . ." If the term "case mix" included the concept of the mix of financial conditions of a hospital's patients, there would have been no need for the quoted language in Section 1395ww(a)(2)(B). As a statute must be construed to give meaning to each of its parts,[8] the enactment of this language demonstrates that the District Court erred in concluding that the term "case mix" "includes the concept of 'significant disproportionate number of low-income patients.' "

The legislative history also supports this conclusion. For one thing, the committee reports demonstrate that Congress referred to "case mix" in the context of indices of case mix complexity which, like the Yale University system which it specifically mentioned, dealt with medical condition. See, e.g., S.Rep. No.

(Cont'd)

Care Facilities, Inc. v. Gibbs, 838 F.Supp. 881, 912 (D.N.J.1993); Multicare Medical Center v. Washington, 768 F.Supp. 1349, 1361-62 & n. 3 (W.D.Wash. 1991).

8. United States v. Nordic Village Inc., 503 U.S. 30, 34, 112 S.Ct. 1011, 1015, 117 L.Ed.2d 181 (1992); United States v. Bernier, 954 F.2d 818, 819 (2d Cir.1992).

97494, 97th Cong., 2d Sess. 24-25 (1982), reprinted in 1982 U.S.C.C.A.N. 781, 800-01; H.R.Conf.Rep. No. 760, 97th Cong., 2d Sess. 418 (1982), reprinted in 1982 U.S.C.C.A.N. 1190, 1198; See also 17 Fed.Reg. 43296, 43303 (Sept. 30, 1982). For another, at least two subsequent amendments to the statute demonstrate that Congress does not regard "case mix" as embracing the mix of financial conditions of patients.[9]

Were there any doubt concerning this conclusion, and we think there is not, it would be resolved by the Secretary's construction of the statute. The Secretary repeatedly has construed the term "case mix" to refer to the types of medical cases treated by hospitals. See, e.g., 47 Fed.Reg. 43296, 43303 (Sept. 30, 1982) ("case mix" relates to "number of possible combinations of diagnoses, procedures, complications and admitting status"); 47 Fed.Reg. 43282, 43285 (Sept. 30, 1982) (case mix refers to "pattern of case complexity"). As we have noted already, the Secretary's interpretation of this labyrinthine statute is controlling unless it is plainly inconsistent with the statutory language or manifestly unreasonable. The Secretary's position is in accord with the statutory language for the reasons stated above. Moreover, this result is entirely consistent with the

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9. First, when Congress enacted the DSA provision for PPS hospitals in 1986, it instructed the secretary to "adjust[ ]" "for variations in case mix among hospitals (42 U.S.C. § 1395ww(d)(2)(C)(iii)) and exclude DSA payments made under section 1395ww(d)(5)(F) (id. § 1395ww(d)(2)(C)(iv)) when computing updated PPS reimbursement rates. If "case mix" included the concept of the financial condition of a hospital's patients, Section 1395ww(d)(2)(C)(iv) would be rendered meaningless. Second, in 1990, Congress amended the Medicare statute to instruct the Secretary to place PPS-exempt hospitals on a PPS system and to consider case mix and the treatment of low income patients as separate issues. Pub.L. 101-508, § 4005(b) 104 Stat. 1388-40 (1990). This is not consistent with the contention that "case mix" subsumes the concept of the financial condition of the patients.

very different conceptual underpinnings of the TEFRA and PPS reimbursement systems.

The existence of the DSA is attributable to Congress's conclusion that low-income patients tend to be in poorer health, and therefore to cost more to treat, than others. A hospital that treated an unusually high number *1172 of low-income patients therefore would be treating an unusually high number of patients who tend to be sicker, and to cost more to treat, than others.

The PPS system reimburses hospitals on a DRG basis — that is, it pays per illness, with the payment determined on the basis of national or regional averages for treatment of that illness. PPS hospitals that treat a disproportionate share of low-income patients therefore would be shortchanged — indeed, one might say penalized — for doing so unless the per illness reimbursement were adjusted upward to take account of that fact.

The situation is quite different for a TEFRA hospital. Its reimbursements are based on its allowable costs in its base year. Those allowable costs include any added costs associated with the treatment of low-income patients in the base year. Hence, as long as its proportion of low-income patients does not increase above what it was in the base year, the hospital is not sustaining any extra costs that are not already accounted for in the base as a result of its treatment of low-income patients in the base year. There is, in consequence, no reason that a TEFRA hospital should need or receive reimbursement adjustments simply by virtue of the fact that it treats a disproportionate share of low-income patients. Indeed, if the allowable costs in the base year reflect additional costs of treating low-income patients, the addition of a DSA to a TEFRA hospital's could result in the hospital being reimbursed more than once for the same incremental costs.

We recognize, of course, that a TEFRA hospital may incur added costs that are not included in its base and that are associated with its treatment of low-income patients, particularly if the proportion of low-income patients served increases as compared with its base year. But a TEFRA hospital is not without recourse in these circumstances. It may apply for an adjustment under Section 1395ww(b)(4)(A) and 42 C.F.R. §§ 413.40(g), 413.40(i) (1993). The adjustment, however, would be based on the fact that more of its patients are sicker or require more intensive or extensive care, not on their income levels. See, e.g., 42 C.F.R. §§ 413.40(g)(3)(ii)(D) (1993) (referring to adjustment based on increases in service intensity or length of stay), 413.40(i)(1)(i)(B)(3) (referring to differences in severity of illnesses among patients served).

In view of these considerations, we cannot say that the Secretary's construction of the statute is unreasonable.

Rye's Constitutional Claims

Rye contends that a construction of the statute that would not extend the DSA to it would deprive it of equal protection of the laws. The contention is entirely without merit.

Legislation in the economic and social welfare area, which includes Medicare, is tested under a deferential standard of review. If the statutory "classification has some 'reasonable basis,' it does not offend the Constitution simply because the classification 'is not made with mathematical nicety or because in practice it results in some inequality.' " Dandridge v. Williams, 397 U.S. 471, 485, 90 S.Ct. 1153, 1161, 25 L.Ed.2d 491 (1970), quoting Lindsley v. Natural Carbonic Gas Co., 220 U.S. 61, 78, 31 S.Ct. 337, 340, 55 L.Ed. 369 (1911).

Appendix B

Insofar as Rye contends that the statute is unconstitutional on its face, its challenge must fail. Given the different conceptual underpinnings of the PPS and the TEFRA reimbursement systems, it was entirely reasonable for Congress to provide a DSA in the former but not in the latter.

It of course is possible that a TEFRA hospital might incur added costs associated with the treatment of low-income patients and that it would not receive adequate payment under the TEFRA reimbursement system. It is perhaps even theoretically possible that the application of the statute and regulations in a specific case might yield such an aberrant result as to raise a question of unconstitutionality in application. But no such claim is available here. Rye, as far as the record discloses, has not sought such an adjustment under 42 C.F.R. § 413.40(g) or (i), much less obtained an adverse final decision. Accordingly, any claim that the statute and regulations are unconstitutional as applied to Rye with respect to any given reimbursement ***1173** period is not ripe. Reiter v. Cooper, ___ U.S. ___, ___, 113 S.Ct. 1213, 1220, 122 L.Ed.2d 604 (1993); Williamson Co. Regional Planning v. Hamilton Bank, 473 U.S. 172, 192-93, 105 S.Ct. 3108, 3119-20, 87 L.Ed.2d 126 (1985); FTC v. Standard Oil Co., 449 U.S. 232, 101 S.Ct. 488, 66 L.Ed.2d 416 (1980); CHA, 46 F.3d at 219-20.

Appendix B

Conclusion

Rye claims in essence that it is treated unfairly because no provision is made in TEFRA to reimburse it for the added cost of treating low-income patients, whereas PPS hospitals receive the DSA. As we have shown, however, both the TEFRA and PPS systems make allowance for the added costs of treating patients who require unusual levels of service, albeit in different ways. Congress acted well within appropriate bounds in doing so. Accordingly, for the reasons set forth above, the judgment of the District Court is affirmed insofar as it determines that Rye is not entitled to receive a Disproportionate Share Adjustment pursuant to 42 U.S.C. § 1395ww(d)(5)(F) and otherwise reversed. The case is remanded for the entry of a declaratory judgment consistent with this opinion.

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APPENDIX C — OPINION OF THE UNITED STATES DISTRICT COURT, SOUTHERN DISTRICT OF NEW YORK, REPORTED AT 768 F. SUPP. 82

RYE PSYCHIATRIC HOSPITAL CENTER, INC.,

Plaintiff,

v.

Richard C. SURLES, Commissioner of the Office of Mental Health of the State of New York, and Cesar A. Perales, Commissioner of the State of New York Department of Social Services,

Defendants.

No. 88 Civ. 5922(GLG).

United States District Court,
S.D. New York.

July 2, 1991.

Private psychiatric hospital brought action challenging New York's Medicaid reimbursement rates. On motions for summary judgment, the District Court, Goettel, J., held that New York's minimum utilization adjustments used to calculate Medicaid reimbursement rates for private psychiatric hospitals, resulting in decrease per diem reimbursement rates for hospitals operating at less than 75 percent capacity, violated Boren Amendment and were null and void.

Judgment accordingly.

* * *

Appendix C

Shanley & Fisher, New York City (Frederick A. Nicoll, Charles D. Donohue, of counsel), Bleakley Platt & Schmidt, White Plains, N.Y., for plaintiff.

Robert Abrams, Atty. Gen. of State of N.Y., New York City (William K. Sanders, of counsel), for defendants.

OPINION

GOETTEL, District Judge:

This action presents a challenge to New York's Medicaid reimbursement rates as they are applied to private psychiatric hospitals located within the state.

I. FACTS

Medicaid is a federal/state program through which the federal government offers financial assistance to enable needy individuals to obtain health care. 42 U.S.C. § 1396 et seq. (1988). See generally Wilder v. Virginia Hosp. Ass'n, ___ U.S. ___, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990) (discussing Medicaid program); Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306 (2d Cir. 1991) (same). The federal government only provides a portion of the necessary funding, with the remainder to be made up by the states and localities. If a state wishes to participate in the Medicaid program, it must comply with federal regulations promulgated by the Department of Health and Human Services ("HHS").[1] Included among these regulations is the mandate that

1. The Health Care Financing Administration actually is charged by HHS with reviewing Medicaid plans. For ease of comprehension, however, we will simply refer to HHS.

the state establish a comprehensive reimbursement scheme for health care providers. The reimbursement methodology has undergone dramatic changes since the Medicaid Act's inception, with a very significant amendment occurring in 1980. This amendment to the Medicaid Act, known as the Boren Amendment (the "Amendment"), states that, inter alia, "[a] State plan for medical assistance must provide for payment . . . of the hospital services . . . provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary [of HHS], are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A).[2] This is not simply a one shot deal. Rather, the states are required, "not less often than annually," 42 C.F.R. *84 § 447.253(b)(1), to make findings that its rates are reasonable and adequate. See Wilder, 110 S.Ct. at 2516.

The rationale behind the Amendment was to provide states with greater flexibility in setting reimbursement rates and to promote efficiency and economy. See Pinnacle Nursing Home, 928 F.2d at 1309-10.[3] In response to the Amendment, New York adopted the reimbursement schedules at issue. Specifically, the question in the case at bar relates to the established rates for

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2. While the Amendment passed in 1980, it was not until 1981 that its provisions were extended to hospitals. Previously, its provisions were limited to nursing and intermediate care facilities. See Wilder, 110 S.Ct. at 2513 n. 2.

3. When the Medicaid Act was initially enacted, reimbursement rates were calculated on a reasonable cost-related basis. Thereafter, however, in response to challenges that the federal government was too deeply involved in state reimbursement practices, the Medicaid Act was amended to provide states with greater flexibility. The Boren Amendment represents a further development of this policy. See Pinnacle Nursing Home, 928 F.2d at 1309 (discussing metamorphosis of reimbursement under Medicaid).

private psychiatric hospitals in the state, of which there are eleven, seven of which accept Medicaid patients. We note that while New York's Department of Social Services ("DSS") administers the state's overall participation in the Medicaid program, it is the Office of Mental Health ("OMH") that is responsible for setting the reimbursement rates for private psychiatric hospitals.

Among the most important changes OMH adopted in response to the Amendment was the adoption of a "minimum utilization adjustment" (the "Adjustment"). See 14 N.Y.C.R.R. § 577.7(g). The Adjustment, which ultimately became effective on June 1, 1984, works as follows. If a hospital operates at seventy-five percent capacity or greater, its per diem reimbursement rate is calculated by dividing its allowable costs by its actual number of patient days. However, a hospital operating at less than seventy-five percent capacity will have its costs divided by seventy-five percent of its certified capacity regardless of the actual number of patient days. Thus, the permissible costs are divided by a greater number of beds than were actually utilized during the base year, which is two years before the rate year. This results in a decreased per diem reimbursement rate for hospitals operating at less than seventy-five percent capacity. While there are obviously other provisions articulated in the state's reimbursement regulations, it is the Adjustment that is of paramount concern to plaintiff.[4]

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4. Before the new provisions became effective, OMH published them in the New York State Register and solicited comments of the private psychiatric hospitals in the state. Notwithstanding Rye's objections, the provisions went into effect. In addition, on June 28, 1984, as required by the Amendment, DSS submitted the proposed changes to HHS, which accepted the state's assurances that the changes complied with all necessary statutes and regulations. On November 16, 1984, DSS was notified by HHS that its amendments had been accepted.

Appendix C

Plaintiff Rye Psychiatric Hospital Center, Inc. has now sued the respective heads of both OMH and DSS for declaratory and injunctive relief pursuant to 42 U.S.C. § 1983 (1988), claiming that the state's plan violates both the Boren Amendment and the regulations promulgated thereunder, as well as the equal protection and due process clauses of the Constitution. While at the time this suit was filed it was unclear whether an action under section 1983 could appropriately raise violations of the Boren Amendment, the Supreme Court's decision in Wilder v. Virginia Hospital Association, ___ U.S. ___, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990), definitively recognizes such a claim.[5]

Presently before us are cross-motions for summary judgment. For reasons which will become apparent, we need not resolve each of the plaintiff's claims and arguments. However, we will briefly list them for the sake of completeness. As noted, plaintiff's claim focuses on the rates established by OMH, specifically the Adjustment. Plaintiff argues that defendants' failure to conduct any formal studies, as required by the Amendment, before implementing the new reimbursement rates violates the Amendment. Going hand in hand ***85** with this argument, of course, are the claims that the rates are neither reasonable nor adequate, nor do they result in economically and efficiently operated hospitals. Defendants, while admitting that no formal studies were conducted, suggest that none were necessary in light of the state's prior experience with minimum utilization adjustments, as well as the general acceptance of such adjustments in the community as a means of encouraging efficiency.

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5. Plaintiff's claim for damages based on the reimbursement rates has been abandoned in recognition of the eleventh amendment's prohibition against such actions. We are told that an action for damages is pending in state court, although it has been stayed pending resolution of the instant litigation.

Plaintiff also claims that while the Amendment requires states to "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs," 42 U.S.C. § 1396a(a)(13)(A), defendants' plan fails to do so. Defendants, in turn, claim that they are exempt from this particular section of the Amendment, but even if it does apply to them, they argue that plaintiff does not serve a disproportionate number of low income people as defined by the Amendment.

An additional argument plaintiff raises is that the state's plan fails to comply with the requirement that the state provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates." 42 C.F.R. 447.253(c). In essence, plaintiff argues that the state's appeals procedure, which permits appeals for erroneous calculations based on the rates established, but not for appeals of the rates themselves, see 14 N.Y.C.R.R. § 577.9(a), is insufficient. Defendants suggest that New York's regulation regarding appeals is sufficient since the federal regulation upon which it was based gives discretion to the agency to determine those issues that can be appealed. 42 C.F.R. § 447.253(c).

Plaintiff's last two claims are based on the Constitution's equal protection and due process clauses. Plaintiff argues that while general hospitals with psychiatric units are subject to the minimum utilization adjustments adopted by a different state agency, these hospitals are entitled to rate increases based on low volume, so-called "volume adjustments." Since plaintiff is not entitled to a similar adjustment, it raises an equal protection argument, claiming there is no rational reason behind a distinction between psychiatric hospitals and general hospitals

with psychiatric units.[6] As to its due process argument, plaintiff contends that defendants are applying the minimum utilization adjustment in an effort to force the decertification of some of plaintiff's forty-one beds without affording it an opportunity to be heard. This, it is argued, amounts to a taking of property without due process.

Before turning to the instant summary judgment motions, we note that plaintiff moved for a preliminary injunction while the summary judgment motions were sub judice. Specifically, plaintiff seeks to prevent the state from using the minimum utilization adjustment while this action is pending. The need for such emergency relief is premised on the fact that the federal government recently informed plaintiff that it had been overpaid on reimbursements for Medicare in previous years and that the deficiency will be satisfied through deductions from any Medicare reimbursements to which plaintiff becomes entitled. This debit is entirely unrelated to the case at bar since it involves a completely different federal program, i.e., Medicare as opposed to Medicaid. Nonetheless, plaintiff claims that it was not until the government notified it of the Medicare overpayments that the extent of the damage from the Medicaid reimbursement rates became fully apparent. As we pointed out to the parties at oral argument of the preliminary injunction application, since plaintiff would be required to establish, inter alia, a likelihood of success on the merits or at least serious questions going to the merits before a preliminary injunction could be granted, it would be extremely inefficient for us to decide that issue while the ultimate *86 merits of the case are before us on the summary judgment motions. Thus, we will not address the motion for a preliminary injunction.

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6. As will be discussed, see infra note 9, new rate-setting procedures for psychiatric units of general hospitals have been proposed. This does not change the argument raised by plaintiff with respect to past practices.

Appendix C

II. DISCUSSION

The standard governing motions for summary judgment is well established. Rule 56 of the Federal Rules of Civil Procedure states that summary judgment shall be granted if the moving party can "show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed.R.Civ.P. 56(c). If the moving party satisfies this burden, the party opposing the motion "must set forth specific facts showing that there is a genuine need for trial," Fed.R.Civ.P. 56(e), and there must be more than merely "some metaphysical doubt as to [these] material facts." Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 586, 106 S.Ct. 1348, 1356, 89 L.Ed.2d 538 (1986).[7]

The principal issue raised by plaintiff is defendants' failure to conduct any type of formal study as required by the Boren Amendment. The Amendment specifically mandates that the state adopt a "plan through the use of rates . . . which the State finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A) (emphasis added). Plaintiff contends that the requirement that the state make findings is particularly important since HHS does not review the adequacy of the state's findings, only the adequacy of its assurances. See Wilder, 110 S.Ct. at 2516. Thus, the mere fact that HHS approves a state's reimbursement methodology is not binding when a court is determining whether the state's rates

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7. At oral argument of the summary judgment motions, it became clear to us that the parties were in agreement as to many of the purported factual disputes. Thus, we had them submit statements of contested and uncontested facts in an effort to afford the court a better opportunity to determine whether this litigation could be resolved at the summary judgment stage.

satisfy the Amendment. "When a federal agency has erred as a matter of law, it is within our domain to say so." Pinnacle Nursing Home, 928 F.2d at 1314; see also AMISUB (PSL), Inc. v. Colorado Dep't of Social Servs., 879 F.2d 789, 796 (10th Cir. 1989) ("court must determine whether the plan is procedurally and substantively in compliance with the requirements of the Federal Medicaid Act and its implementing regulations"), cert. denied, ___ U.S. ___, 110 S.Ct. 3212, 110 L.Ed.2d 660 (1990).[8]

Defendants admit to not having conducted a formal study. Instead, in establishing the reimbursement rates, they relied on the successful use of minimum utilization adjustments by the state in other contexts. Specifically, defendants point to the New York State Department of Health's use of minimum utilization adjustments in rate-setting for general hospitals, including those with psychiatric units, since as early as 1976. See 10 N.Y.C.R.R. § 86-1.9. Thus, the state had experience with such rate adjustments and simply decided to extend them to private psychiatric hospitals. Defendants also suggest that the generally accepted view of experts in the field is that minimum utilization adjustments are an important means of forcing hospitals to increase efficiency and economy. Defendants specifically rely on a report from October 1976 by the National Academy of Sciences entitled "Controlling the Supply of Hospital Beds" (the "NAS Report"), which states, inter alia, that surplus beds contribute significantly to the rising costs of hospitalization. Furthermore, the report states that "[r]ecent studies have contained estimates

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8. While not binding, the fact that the state and HHS approved OMH's reimbursement scheme is entitled to deference. See Pinnacle Nursing Home, 928 F.2d at 1313. Our inquiry must focus upon whether the action was " 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.' " Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416, 91 S.Ct. 814, 823, 28 L.Ed.2d 136 (1971) (quoting 5 U.S.C. § 706(2)(A)).

that the cost of an empty bed is 50 percent of the cost of an occupied bed." NAS Report at 15. Finally, defendants argue that they sought feedback from the industry when the Adjustment was adopted *87 and, in fact, five of the seven psychiatric hospitals subject to the Adjustment have not been affected adversely.

We admit that on its face, a minimum utilization adjustment appears to be a rational means of encouraging efficiency. A health care provider that consistently operates below capacity, yet maintains fixed costs associated with its actual capacity, should not be reimbursed for the fixed costs associated with these vacant beds. This is a particularly compelling argument when the state will only certify a fixed number of beds throughout the state. Therefore, a hospital that fails to maximize its capacity should have beds decertified so as to enable the state to allot more beds to hospitals experiencing no difficulties attracting patients. Unfortunately for the defendants, however, the mere fact that there may be strong policy reasons behind the adoption of such a reimbursement adjustment is insufficient. The Amendment has specific requirements that must be satisfied and post-hoc rationalizations simply do not suffice. See West Virginia Univ. Hosps., Inc. v. Casey, 885 F.2d 11, 30 (3d Cir. 1989) ("[f]ederal law is not satisfied if a state merely makes conceptual policy decisions"), cert. granted, ___ U.S. ___, 110 S.Ct. 1294, 108 L.Ed.2d 472 (1990).

Notwithstanding the defendants' contentions as to why formal findings were unnecessary, the law of this circuit is unequivocal. In the recent decision of Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306 (2d Cir. 1991), the court was presented with a challenge by a number of nursing homes to an amendment to the state's Medicaid reimbursement methodology for such facilities. Although the state had conducted findings and given

assurances to HHS, the court considered them inadequate. In so holding, the court rejected the state's contention that requiring further findings was an " 'additional and rigid procedural requirement[ ]' not mandated by the [Boren Amendment]." Id. at 1313 (quoting Defendants' Brief). Specifically, the court stated that while a state need not submit findings to HHS, only assurances that the requisite statutes and regulations have been complied with, before making such assurances "the state must engage in a findings process." Id. at 1313 (citing AMISUB(PSL), 879 F.2d at 796); see also Wilder, 110 S.Ct. at 2519 n. 11 ("[t]he requirement that a State make such a finding is a necessary prerequisite to the subsequent requirement that the State provide 'assurances' to the Secretary"). The court appeared particularly influenced by the mandatory rather than precatory language of the Amendment, which requires that the state " 'must' provide for payment of rates which the state finds are reasonable and adequate." Pinnacle Nursing Home, 928 F.2d at 1314 (quoting 42 U.S.C. § 1396a(a)(13)(A)); see also Wilder, 110 S.Ct. at 2518 (recognizing that "Boren Amendment is cast in mandatory rather than precatory terms"). After stating that findings were mandated by the Amendment, the court reviewed the findings and assurances at issue. Since neither was sufficient, the court concluded that the procedural requirements of the Amendment had been violated and the provisions at issue were declared null and void. Pinnacle Nursing Home, 928 F.2d at 1316. The court remanded the case to district court for resolution of the substantive and constitutional claims asserted by the nursing homes, "if and when the state submit[ted] proper findings as required by the Boren Amendment." Id. at 1318.

Thus, the requirement that findings be made before the state amends its reimbursement methodology is clear. Defendants' admission that they did not make such findings is, therefore, fatal

and the Adjustment must be deemed null and void. Moreover, a brief analysis of the reasons offered by the defendants for not conducting any formal findings makes it readily apparent why the requirement is mandatory.

The state initially relies on the Department of Health's use of minimum utilization factors in general hospitals since 1976. While it is true that the general hospitals, including those with psychiatric units, have utilized such factors since 1976, the state has also permitted volume adjustments for those hospitals experiencing below average *88 lengths of stay. See 10 N.Y.C.R.R. § 86-1.12. While we need not get into the specifics of such volume adjustments, they diminish the hardships imposed by minimum utilization adjustments by artificially increasing a hospital's actual occupancy rate. As the state admits, one of the rationales behind volume adjustments is to "ameliorate the adverse effects of shorter lengths of stay, and reductions in the number of admissions, by recognizing that fixed costs cannot be adjusted immediately to account for changes in volume." Defendants' Statement Concerning Non-Stipulated Facts & Proofs ¶ 16. Also, volume adjustments prevent hospitals from unnecessarily extending patients' periods of hospitalization in order to meet minimum utilization guidelines. While the defendants contend that it is inapposite to compare the reimbursement rates for general hospitals with the psychiatric hospitals at issue because they are controlled by different state agencies, i.e. the Department of Health and the Office of Mental Health, this misses the crucial issue before us at present. The state does not apply a straight minimum utilization adjustment in general hospitals. Thus, its reliance on the use of minimum utilization adjustments in general hospitals as a basis for utilizing such adjustments in psychiatric hospitals is simply misplaced. Perhaps, plaintiff argues, it should be entitled to volume

adjustments because episodically ill mental patients do not have long periods of hospitalization. This is precisely the reason why findings by the state are necessary.[9]

The second factor relied on by defendants in arguing that formal findings were unnecessary is the fact that minimum utilization adjustments are allegedly an accepted means of increasing efficiency. The specific report they rely on, however, belies this argument. The NAS Report, see supra page 86, focuses upon short-term general hospitals, see NAS Report at 1, and at least one of the studies conducted excludes data involving mental hospitals. Id. at 8 n. 1. The report further states that the goal of reducing beds "should be applied flexibly . . . paying particular attention to the differences between medical-surgical beds and obstetrical, pediatric, and other specialized care beds." Id. at ix. A separate study cited by plaintiff claims that "partial debedding programs, programs to induce or require hospitals to remove beds from service, are unlikely to produce significant cost savings, particularly if those reductions occur primarily in small or medium-sized hospitals." M. V. Pauly & P. Wilson, Hospital Output Forecasts and the Cost of Empty Hospital Beds, 21 Health Services Research 403, 424 (August 1986). Thus, in a small hospital like plaintiff's, which has only forty-one beds, there may not be significant costs associated with eleven (approximately

9. As we previously suggested, see supra note 6, rate-setting methodologies for the psychiatric units of general hospitals are being amended. These changes may ultimately be applied to private psychiatric hospitals as well. An important modification involves the elimination of volume adjustments. Again, we need not discuss the change, but only mention it to show how, once again, the state has treated general hospitals differently than psychiatric hospitals. While the state certainly has the right to do so, the disparate treatment afforded the different types of hospitals is further support for plaintiff's contention that the state cannot simply rely on its use of minimum utilization adjustments in general hospitals as a means of avoiding the specific statutory requirement of conducting findings.

twenty-five percent) vacant beds. In a hospital with one thousand beds, however, a twenty-five percent vacancy rate means that two hundred fifty beds are vacant. Such a large number of vacant beds obviously has greater costs associated with them than would eleven vacant beds. Just the space that would be required to house those additional two hundred fifty beds would be extremely expensive.[10]

Another study plaintiff points to suggests that we should only look to the hospital beds that are actually set for patients. See Letter of June 21, 1984 from R. Manderscheid, *89 Chief, Survey & Reports Branch, Nat'l Inst. of Mental Health, to J. Schoenholtz, Chairman, New York State Ass'n of Private Psychiatric Hosps. In the case at bar, plaintiff has twenty-seven beds in its main building and another fourteen beds in a cottage. Since plaintiff was operating at about fifty percent capacity, only the main building was being utilized. This is an important factor since costs related to the forty-one beds vary depending upon whether the beds are being utilized or not and, if not, whether the empty beds are in the main building or the cottage. For example, if the cottage remains vacant it might not require heat or extensive maintenance, but a vacant bed in the main building still has these costs to consider. Thus, an argument can be made that rather than determining reimbursement rates based on seventy-five percent of forty-one, the proper equation would calculate seventy-five percent of twenty-seven. Again, we need not resolve this issue, but it is certainly something the state can consider in conducting its findings.

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10. Defendants suggest that the Pauly and Wilson article is not relevant to the type of reimbursement methodology adopted by the state in the instant case. This may be true, but it is something that can be explored by the state in conducting its findings in accordance with federal statutes and regulations.

Finally, there are a number of other questions raised by the rates defendants have set. For example, it is unclear why seventy-five percent was selected as the cutoff, rather than eighty or seventy percent. Moreover, it is unclear why the state looks to a period of time two years before the rate year to determine if the seventy-five percent occupancy has been satisfied. Why not one or three years? By these questions, we do not suggest that the rates as presently established do not comport with federal law. That is an issue for another day, after the state has made the necessary findings. It would be illogical for federal courts to engage in fact finding missions while the state agencies with expertise in the particular field sit on the sidelines.[11]

III. CONCLUSION

For all the foregoing reasons, we declare New York's minimum utilization adjustment as codified at 14 N.Y.C.R.R. § 577.7(g) to be null and void. The remaining challenges made by plaintiff need not be addressed until the state cures this procedural violation of the Boren Amendment. See Pinnacle Nursing Home, 928 F.2d at 1318.

SO ORDERED.

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11. With respect to the findings the state must conduct, we see nothing to prevent the state from looking to its experience with the Adjustment with private psychiatric hospitals from 1984 until the present date. For example, plaintiff argues that the Adjustment encourages hospitals to increase patients' periods of hospitalization, while the defendants contend that nothing of the sort has occurred. The state can certainly consider this issue in making its findings. Moreover, we note that for general hospitals, state law spells out specific factors to be considered by the Department of Health in adopting rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." N.Y.Pub.Health Law § 2807(3) (McKinney 1991).

APPENDIX D — RELEVANT STATUTES AND REGULATIONS INVOLVED

42 U.S.C. § 1395ww. Payments to hospitals for inpatient hospital services

(a) Determination of costs for inpatient hospital services; limitations; exemptions; "operating costs of inpatient hospital services" defined

(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning —

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this subchapter.

Appendix D

(ii) The Secretary shall set such limits for a cost reporting period of a hospital —

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)(3)(B) of this section).

(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account —

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education

costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

* * *

(4)(A)(i) The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results

in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

(ii) The payment reductions under paragraph (3)(B)(ii)(V) shall not be considered by the Secretary in making adjustments pursuant to clause (i).

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42 U.S.C. § 1395f

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(b) Amount paid to provider of services

The amount paid to any provider of services (other than a hospice program providing hospice care, other than a rural primary care hospital providing inpatient rural primary care hospital services, and other than a home health agency with respect to durable medical equipment) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1395e and 1395ww of this title, be —

* * *

(2) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its

patients are low-income (and requests that payment be made under this paragraph), free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services; or

* * *

42 C.F.R. § 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) *General considerations.* (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.

(i) The number of beds in a hospital is determined in accordance with § 412.105(b).

(ii) The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.

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